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HEALTHAMERICA LEGISLATION

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COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

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FIRST SESSION

ON

S. 1227

EXAMINING REFORM OF THE NATION'S HEALTH CARE SYSTEM TO ASSURE ACCESS TO AFFORDABLE HEALTH CARE FOR ALL AMERICANS, FOCUSING ON HEALTH AND ECONOMIC IMPLICATIONS

June 11 AND 12, 1991

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HEALTHAMERICA LEGISLATION

TUESDAY, JUNE 11, 1991

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Wellstone, Hatch, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. We'll come to order.

I'm going to put in the record my statement about the health care crisis that we're facing in this country, with increasing numbers of people who are uninsured—approximately 37 to 40 million Americans—and some 60 million Americans who have insurance that even the Reagan administration said would be inadequate in the event of serious illness. That is about one-third of all Americans. The other 150 to 175 million Americans for the most part are just a pink slip away from losing all of their coverage. And we have extraordinary escalations of costs which are depleting the resources of families and denying access to people in real need.

We have seen the introduction of legislation to try to deal with this issue which has been introduced by the majority leader, Senator Riegle, Senator Rockefeller and myself. We have had working groups between this committee and the Finance Committee. The initial groups were bipartisan. We are very hopeful, as the majority leader has said, of finding consensus. This is a compromise piece of legislation. We welcome the suggestions and recommendations of those who have been most involved in following health policy over a long period of time.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

I am pleased to open this first hearing on the historic HealthAmerica legislation introduced last week.

I have been working on the issue of the availability and cost of health care for many years. Never have we been closer to guaranteeing affordable health care for every citizen of these United States than we are today. And never has the need for action been greater, because our health care system is collapsing, and reform is long overdue.

The crisis has two central features. Too many Americans have no insurance or inadequate insurance. And health care costs are out of control.

During the Great Depression, President Franklin Roosevelt called us to action with his statement that "One-third of our nation is ill-housed, ill-clad, and ill-fed."

Today, more than a third of the nation is ill-prepared when serious illness strikes. They lack the basic health insurance coverage that every other industrialized nation except South Africa grants as a fundamental human right.

Thirty-four million Americans have no health insurance coverage. Two-thirds of them are working men and women and their families. Fifteen million Americans every year are turned away when they ask for health care, or do not even seek the care they need, because they know they cannot afford it. Sixty million more Americans have insurance that even the Reagan administration said would be inadequate in the event of serious illness.

Today, a third of the nation must live with the knowledge that a serious accident or illness can wipe out the savings of a life-time. Even those with adequate insurance must live with the knowledge that they and their families are only one pink slip away, or one decision by their boss to cut costs away, from losing coverage.

We will hear from some of these hard-working Americans today. In a very real sense, they have more to tell us than all the high-priced health care experts or powerful interest groups. One of the families we will hear from today has accumulated hundreds of thousands of dollars in debts as they struggle to care for their sick child.

The second part of the problem is the escalating cost of health care, which burdens our economy and threatens to price health care out of the reach of average citizens.

American corporations are increasingly cutting back coverage or sacrificing profits and international competitiveness as they try to provide adequate insurance for their workers. We pay 40 per cent more per person than Canada, and twice as much as Germany and Japan.

The program we have proposed is a comprehensive one. The central feature is called "play or pay." It will require every employer to provide coverage for workers and their families, or else contribute a percentage of payroll to the cost of public health insurance coverage under the new AmeriCare program. The unemployed will also receive coverage through AmeriCare, with premiums based on ability to pay.

The cost problem will be addressed through provisions dealing with all parts of the problem—cost-shifting, unnecessary care, excessive administrative costs, and the blank-check reimbursement to providers.

The plan is a compromise. It is not a government take-over of the nation's health care system. But it is designed to eliminate the worst faults of the current system, while preserving its most essential aspect—the public-private partnership we use today. Our goal is to build on the current system, not abandon it.

The broad thrust of the program will be endorsed today by two distinguished former Secretaries of Health, Education, and Wel-

fare. One, Joe Califano, is a Democrat. The other, Elliot Richardson, is a Republican. Both are men of outstanding vision and a deep understanding of the current system and the challenges we face to improve it.

Some say that the time is not yet ripe for reform, and that greater consensus is necessary before action can be taken. But the longer we delay, the worse the problems become, and the more costly the solution will be. Now is the time for action, and this is the Congress for action. I welcome our witnesses, and I look forward to their testimony.

This morning we have two individuals who are former secretaries of HEW who have devoted an enormous amount of time and energy and thought to this issue, and for whom I have both enormous respect and friendship.

I think their commitment to public service is demonstrated by the fact that not only when they had positions of public trust did they dispatch those responsibilities with great expertise and compassion and efficiency, but they have maintained their own private interest in making recommendations and helping this Nation to find some path toward more sensible and compassionate and responsible health policy.

So I welcome both of them here this morning—Secretary Califano, former Secretary of the Department of Health, Education and Welfare, and Elliott Richardson from my own State of Massachusetts, who is also a former Secretary of the Department of Health, Education and Welfare. We'll start off with you, Mr. Califano.

STATEMENTS OF JOSEPH A. CALIFANO, JR., ATTORNEY, DEWEY BALLENTINE LAW FIRM, AND FORMER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, WASHINGTON, DC; AND ELLIOTT RICHARDSON, ATTORNEY, MILBAND, TWEED, HADLEY AND McCLOY LAW FIRM, AND FORMER SECRETARY DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, WASHINGTON, DC

Mr. CALIFANO. Thank you, Mr. Chairman. I am delighted to be here and delighted to be here with Secretary Richardson.

I congratulate you, Senator Majority Leader Mitchell, Senator Riegle, Senator Rockefeller and others who have worked so hard to develop the HealthAmerica bill.

This legislation comes at a crucial time, a time of frustration and desperation. The inadequacies of our health care system and its insatiable appetite for our resources have reached the point where some politicians and health care experts have even embraced rationing as a solution.

For decades, we have rationed care by our wallets—those with the thickest wallets get the best care. Many of those with empty wallets get little or none. For the future, many experts propose to distribute care "more intelligently" and "more fairly" by subjecting most of the population to the rationing now reserved for the poor.

Oregon proposes to deny the poor access to certain treatments so that more poor citizens can receive some care. The Bush administration has decided to ration Medicare for the elderly by explicitly

weighing cost as a factor in determining whether to cover new procedures, devices and drugs.

Rationing is a macabre dance of despair, choreographed by the failure of half-hearted efforts to rein in health care costs, by extravagant waste, by refusing to provide timely care to the uninsured middle class and the poor, by self-indulgent lifestyles, and by the perplexing proliferation of paper work that makes checking the right box and picking the right insurance code more important than finding the right diagnosis and providing the right care.

This fall, Americans will break the two billion dollar a day barrier in health care spending. The willingness of our citizens to spend $750 billion on health this year should be an opportunity to release the poor from rationing and give all Americans all the care they need.

Instead, the new melody rising to the top of the health policy charts is to ration care—this time, by rules orchestrated by many of the same politicians, bureaucrats and physicians who got us where we are today. Wanting to play God rather than serve him, they now claim the wisdom to decide who should suffer how much pain how long, who should walk and who should limp, who will live, who will die, and when.

The HealthAmerica legislation recognizes that the three-quarters of a billion dollars we will spend this year is more than enough to provide all the health care all our people need. This bill would stop the rationing of care by the size of people's wallets and take the cost containment steps necessary to avoid rationing by any means in the future.

The HealthAmerica legislation recognizes that both access to health care and control of costs are necessary.

To provide health insurance for the 34 million people who now lack it, the bill requires a minimum health care benefit, just as we now have a minimum wage law. Most Americans, about 150 million, have health care coverage through the employment relationship. HealthAmerica builds on that remarkable achievement. It requires that each employer assure its employees a minimum level of health care: physician treatment, hospitalization, diagnostic tests, and important preventive services like mammograms. The program would be phased in gradually, just as the minimum wage was, to reduce the impact on small employers.

An employer would pay 80 percent of the cost of coverage or, if it chooses not to offer a health plan, contribute a percentage of employee payroll to a new government-sponsored plan. This plan, based on the Medicaid program, would cover the poor, the temporarily unemployed middle class, and those not offered coverage by their employers. Covered individuals would make premium payments geared to their income.

The HealthAmerica cost containment provisions will eliminate waste and provide better quality care to our people. At least 25 percent of the money we now spend on health care is wasted. That is more than $180 billion this year, including 40 billion taxpayer dollars. This bill attacks that waste.

Malpractice premiums and the cost of defensive medicine together amount to some $30 billion a year in health care spending.

HealthAmerica gives States incentives to reform their malpractice laws, as California and other States have successfully done.

Half the coronary bypasses, most Caesarean sections, and a significant proportion of many other procedures such as pacemaker implants, hysterectomies and tonsillectomies, are unnecessary or of questionable value. HealthAmerica doubles the research effort to find out which medical procedures work under what circumstances. It would require government insurers like Medicare to use the resulting practice guidelines in setting reimbursement.

Small employer insurance premiums can run 40 percent higher than those of larger businesses. This year for the first time, the cost of administering our health care system will top $100 billion. HealthAmerica sets up insurance consortia and reforms small business insurance to reduce costs to the small employer and to slash administrative costs that are driving doctors, hospitals and patients to distraction.

Not surprisingly, the objections of some to the legislation echo the objections of those who opposed the minimum wage and Social Security laws when they were proposed a half-century ago.

Fortunately, much of American business sees the need for health care reform not simply as a matter of fairness, but as a matter of jobs and profits. The skewed distribution of rocketing costs on key industrial gains has put them at a decided disadvantage in world markets—and that's about the only kind of markets our children are going to live and compete in.

In the auto industry, for example, American manufacturers like Chrysler pay about $700 for each car for health care, while their German competitors pay about $350 per car, and their Japanese competitors about $250.

Similar competitive disadvantages in health care costs make it impossible for the American electronics, communications, steel, and other industries of the 21st century to compete with other industrialized nations. Those nations provide health care on an equitable basis to their citizens. The HealthAmerica bill will distribute costs fairly so that these U.S. industries will no longer have to carry the burden of cost-shifting to pay for the uninsured that other businesses and government do not cover.

Business spending for health care has soared from 14 percent of after-tax profits in 1965 to more than 100 percent in 1989. Many of those billions could have gone to shareholders in higher profits, to workers in higher pay, or to plant modernization, research and development to make our industries more competitive. Even a 10 percent reduction in total business health care costs would generate more than $20 billion for these purposes.

To deny American industry the benefits of the cost savings that the bill will produce is to shoot ourselves in the feet—both of them—as our foreign competitors lace up their Nike running shoes.

American business and labor can win against the intensifying world competition in every phase of industrial life—but only if they have a fair and level playing field. We don't need trade agreements and tariffs, years of administrative litigation about dumping by foreign companies, or years of international negotiations to deal with the devastating competitive disadvantage health care costs impose on our major industries. All we need is to get our own act

together. That's what HealthAmerica does for American business and for American jobs.

I predict that corporate America will support this bill wholeheartedly because it is in the interest of their shareholders and workers and will help increase their profits.

The HealthAmerica bill addresses the concerns of many in the business community that increasing access would unleash a new round of cost increases such as those which followed the introduction of Medicare and Medicaid 25 years ago. This is unlikely for three reasons.

First, we have tremendous excess capacity in the system—as many as 400,000 underused hospital beds, more physicians and more high-tech medical equipment than we need.

Second, employers that now cover their employees will not be subject to cost-shifting; each company will pay its own way.

And third, the Federal Health Expenditure Board which the act creates will exert a powerful influence on payment rates.

HealthAmerica is a triple crown winner. Patients win because for the first time they will have continuous access to affordable and timely care, wherever they are employed and when they change jobs or are out of work. Business wins because costs will be restrained and fairly distributed. Doctors, hospitals and other providers win because HealthAmerica will cut the administrative hassle and free them from the burden of uncompensated care.

This is a bill that, if they think about it, all the players in the health care arena can support, and I believe in the end they will. Why? Because the alternative to action is a grim future.

Many workers and retirees will lose their employer-based coverage or have it drastically reduced—something that is happening today. Medicare beneficiaries will wait in line for lower quality care. Millions of citizens will continue to be denied access to basic health care. And only the wealthiest Americans will be able to afford high quality care.

Make no mistake about it, Mr. Chairman. What is at stake is not health care for the unemployed and the poor. What is at stake is our entire world class medical system. Just about every major medical center in America is now at risk, slipping each year into deeper trouble. For many, lack of resources, loss of topflight doctors, and the mounting burdens of uncompensated care and red tape have already brought them to a crisis stage.

This future is not a fantasy, and it is not far away. Fortunately, the money needed to avoid it is already allocated to health care. We need only spend that money wisely. If we do, we can provide higher quality health care for all our citizens at the same price we are now paying to provide a declining quality of care only for some.

Mr. Chairman, again I congratulate you on the thought and effort that went into this bill and for your commitment over the years. I congratulate majority leader Mitchell and the other Senators for their determination to have the Senate act on this legislation in this Congress. Thank you.

The CHAIRMAN. Thank you very much, Secretary Califano.

I'd like to call on our ranking minority member Senator Hatch before Mr. Richardson. He has to attend a Foreign Relations Com-

mittee meeting, and he has been very much involved in health policy generally. I will recognize him now.

Opening Statement of Senator Hatch

Senator Hatch. Thank you, Mr. Chairman.

I want to welcome both of you here and all the other witnesses as well. You have both been friends through the years, and you both are very articulate and solid spokespersons in this area. So I particularly think the committee has benefited by your testimony.

Mr. Chairman, there is no argument that we face an increasing crisis in our health care system. But this crisis has no partisan nature, and we should be able, it seems to me, to work in concert to design solutions.

The major agonist in our current crisis is having health care costs absolutely out of control. In the past I have sponsored many cost containment proposals, including medical liability reform, development of medical practice standards, publication of cost and quality data for all providers, and reform of the small group health insurance market systems.

I am pleased that there is a growing consensus for these reforms as reflected in the legislation proposed by my distinguished colleagues, Senators Kennedy, Mitchell, and others.

With cost containment, the most important part of any program to increase access to care and with almost total agreement on most cost containment strategies, why does this legislation have to have a partisan tilt to it?

The real difference in how to solve the problem is how to pay for it. The Mitchell plan financing mechanism is all too typical: Break the bank; make others pay the costs. The "pay-or-play" mechanism makes this legislation a job-loss bill, not an enhanced access to care bill.

The Partnership on Health Care and Employment estimated that up to 3.5 million jobs could be lost as a result of the employer mandates in this "pay-or-play" scheme. And we know whenever we go to a system of mandates, they have never really worked. Mandates on employers limit both employers' and employees' flexibility, dampen their creativity and in the case of health insurance, may threaten their very survival.

It is particularly concerning that the "pay-or-play" mandate will fall hardest on employers who offer entry-level jobs—the very jobs we need in this country to enhance family and societal stability. These entry-level jobs are often part-time or a second job or spousal employment. These kinds of employees may choose not to be covered by health insurance. "Pay-or-play" will provide them something they may not need or even want—and perhaps at the expense of having any job at all.

It is clear that many of these employers are on a thin margin. An 8 percent increases in their taxes, essentially applied to their gross receipts since their expenses are heavily payroll, and they have no profit, could drive them out of business. And if small employers fail, so does our job creation capacity because most job creation is made in the small business area—in fact, most creativity comes from the small business area.

In reality, "pay-or-play" is a mandate on the backs of American workers. What they get is loss of jobs, loss of flexibility and loss of wages.

In addition, what is to stop current employers from dropping their insurance coverage and paying into the public program? They would have every incentive to do it. And there wouldn't be enough by paying the 8 percent to really pay for the costs that we're all hoping we can find some way to cover.

I recently talked to a small employer in Utah who does provide health insurance to his employees. He pays 12 to 15 percent of his gross payroll for these particular benefits. He works hard to keep his health care costs down while working hard to provide for his employees. It would be easier, both economically and administratively, to simply pay 8 percent for the public plan. I am concerned that the public program will never be adequately funded—yet over 65 million Americans might be covered under the public program—at least that is the estimate.

The rate regulation proposed in the Democratic bill is an anachronism. Can't we learn anything from the last 50 years of experience with bureaucratic, centralized regulatory planning and control? At a time when Eastern Europe is emerging from the yoke of centralized price and wage planning, why would we choose to adopt it?

We have repealed the notorious certificate of need regulatory monster because it made things worse. Hospital costs in rate-regulated States have increased faster than the national average, and much faster than in the nonregulated States. Medicare physician expenditure targets, RBRVS, have led to increased costs because of all too predictable volume phenomena. And all this has led to more proposed regulation.

Rate regulation ignores the only proven way to control costs, and that is the market. Rate regulation tends to freeze inequities as they currently exist and leads to rationing via the back door.

Who is to say how much we should spend and on what we should spend it? That should depend on individual freedom of choice. Expenditure targets would ration care from on high leaving costly distortions in a "centrally planned" health system, and regulation in my opinion will not work to control costs.

The only proven mechanism for controlling costs is to make individuals themselves more responsible for their own purchasing. All sectors of the health industry—employers, insurers, providers, professionals—have to take responsibility for restraining costs, and the government must make sure that there are proper incentives for cost constraint by all of those sectors and do its part in funding safety net programs.

Mr. Chairman, we should now focus our attention on common ground approaches to controlling costs and not spend valuable weeks wrangling over financing schemes and regulatory bureaucracies and overkill that will cost our workers jobs and offer little hope for increasing access or decreasing health care costs.

Mr. Chairman, I am anxious to continue our longstanding cooperative approaches to addressing our health care needs. I think we have to try—you and I and others on this committee—to avoid partisan politics in this truly national crisis. If we do, I have no doubt

in my mind that we can solve this problem and do it in a comprehensive way that will help to bring health care to everybody in America on the basis of the lowest possible cost and the best possible care.

I don't think we do it by rate regulation, by mandates on the backs of small business people, and by some of the over-regulatory approaches that I think are in the present bill.

But having said all that, I want to personally pay tribute to our chairman. He has been raising this issue since the early Seventies, and this is the time where we've got to solve it.

I happen to know that the chairman has a great desire to solve it, and I think he has a desire to solve it in a bipartisan way. Unfortunately, right now it is not in a bipartisan mode, but I think we can get it there, and I would like to get it there. And I would like you two gentlemen and all the other witnesses here to help us to get it there, because this isn't the way we're going to go and this isn't the way it should go, because if we are going to go straight with "pay-or-play" or we're going to go straight with these over-regulatory approaches or we're going to go straight with a centrally-planned health care system, I think we're all going to lose. I don't have any doubt about it, and I don't think you should have any doubt about it. Both of you have had tremendous experience in this area, and I'm not going to discount or disregard anything you have to say because I have listened to both of you through the years and have great admiration for both of you, although we have disagreed from time to time.

But I have no doubt in my mind that the distinguished chairman has done more than any other person in this country to bring this issue to the forefront. Now I am challenging our distinguished chairman to do more than anybody else to see that it is done in a bipartisan way, in a way that will work, in a way that ignores all of these excesses of the past for which he is so well-noted—I'm only kidding. [Laughter.]

Ted deserves a great deal of credit, and we're going to get this done, as far as I'm concerned, and I just hope everybody will cooperate in helping us to do it. It means that those on my side have got to move in order to get it done, and those on the other side have got to move, too. And it really deserves a national bipartisan approach that will really resolve these problems in the best interest of everybody.

I hope we can do that, and Mr. Chairman, I pledge myself to that end, and I'm going to do everything I can to help.

The CHAIRMAN. I appreciate Senator Hatch's comments. We have teamed up on a number of pieces of legislation. Usually when we do, people say one of us hasn't read the legislation. But that won't be true when we team up on this.

That is a wonderful introduction for you, Secretary Richardson.

Senator HATCH. Will you forgive me—I have a markup in the Senate Foreign Relations Committee, and I feel like I've got to go, but I hate to miss a minute of this because I think it is very important. But I will read both of your statements and the statements of all the other witnesses as well, and I'm happy to welcome all of you here.

Mr. RICHARDSON. Before you go, Senator Hatch, I would simply like to point out the fact that Secretary Califano and I do represent a bipartisan approach, and I think the chairman must have had that in mind when he invited us to testify.

Senator HATCH. Well, I have seen you two side-by-side before in many ways, and it is not surprising to see you side-by-side today. I am just pointing out that there may be some additional approaches that might work as well.

The CHAIRMAN. Mr. Richardson, please proceed.

Mr. RICHARDSON. Thank you very much, Mr. Chairman and members of the committee. I warmly welcome this opportunity to testify on an issue whose critical importance has been very effectively underscored by Mr. Califano. It is a pleasure to appear here today in association with him.

The issue of health care, Mr. Chairman, is one, as of course you well know, with which each of us has been involved, indeed in which both of us have worked from time to time together, for the better part of 20 years. It sometimes seems to me that the only thing that has changed during those two decades is that the problem itself has become worse and worse.

That very fact is, of course, what makes this hearing on health care so important and so timely, and I applaud your initiative in convening it.

When I began working on this problem for the Nixon administration, there were perhaps 26 million health uninsured, and we viewed that as a national scandal, even though at that time the number was declining every year. Today, the number, as you pointed out, is somewhere between 34 and 37 million, and it is growing every year.

Beyond the growing numbers of the uninsured, the level of insecurity faced by the average American family about its ability to keep the insurance it may have acquired is unprecedented.

While 34 million Americans may be uninsured at a particular point in time, the Census Bureau found that 63 million would be uninsured for some substantial time over a two-year period. With changes in insurance company practices, it has become difficult or impossible for individuals who have had any kind of serious health problem to buy insurance at an affordable price.

Businesses are increasingly cutting back on the coverage they offer. Far more than in 1971, average Americans cannot be confident that they will be able to afford the cost of a serious illness or have access to the health care they need.

The second side of the problem that has gotten much worse is the cost of health care and its burden on our economy—a problem that was not nearly so visible in 1971 when health care accounted for only about 7 percent of our gross national product, and a day in the hospital cost about $100. In 1991, the share of GNP devoted to health care is over 12 percent, and a day in the hospital costs more than $600.

Increasingly, American businesses are worried about the impact of health care costs on international competitiveness and productivity, a point very effectively made just now by Mr. Califano. In 1970, these costs amount to about one-third of corporate profits.

Today, businesses actually spend slightly more on health care than they earn in after-tax profits.

In addressing the health care problem in 1971, we decided that universal, equitable access to health care could be achieved by only one of two routes. The first alternative would have been to move toward a European or Canadian-style health insurance model in which the sole responsibility for financing health care and determining benefits to be covered would rest with the government. As a conservative Republican administration, we felt a greater role for the private sector would make more sense in the American context and leave more room for choice, diversity and experimentation.

The second alternative, the one we chose, would have required employers to provide coverage to workers and their families and established a Federal-State program to cover the unemployed. We recognized that if we were to maintain the private, employer-based system that insures most Americans, these requirements were essential. If we established a tax-subsidized public program for all Americans that employers did not cover and did not at the same time establish some requirements on employers, there would be two undesirable outcomes.

First, taxpayers would have to pick up the cost of uninsured workers, thus increasing the budget impact of the program substantially.

The second problem, a more basic one, was that with the availability of subsidized public coverage, there would be little incentive for employers to keep providing coverage for their workers, and ultimately everyone would end up covered under the public program.

Additional features of our plan included reform of the small business insurance market, establishment of a catastrophic cap on out-of-pocket costs for covered services, and a basic benefit package that allowed reasonable copayments and deductibles.

The proposal that you have introduced, Mr. Chairman, includes all of these features of our plan. But it also includes two major innovations that are particularly noteworthy.

First, the proposal substitutes the so-called "play or pay" system for a simple mandate to provide coverage. Under the "play or pay" system, the employer has a choice between providing coverage or making a contribution tied to a percent of payroll—perhaps 7 or 8 percent—that will pay part of the cost of coverage for his employees under the Federal-State program.

One of the major concerns about our plan was the impact it would have on employers, particularly small employers, with predominantly low-wage or part-time workers. This was the problem, of course, referred to just a few minutes ago by Senator Hatch. Your proposal does, of course, specifically address that problem. For these employers, the requirement to provide coverage could have resulted in a substantial percentage increase in total compensation, which might be difficult to afford. The "play or pay" approach in effect caps the employer contribution at an affordable level.

In addition I note that your plan includes substantial tax subsidies for small businesses that might have trouble affording the cost of the program.

The second major innovation in your plan, Mr. Chairman, is an extremely comprehensive cost control program. Your proposal has a series of resourceful measures to deal with all four parts of the cost problem—cost-shifting, unnecessary care, excessive administrative costs, and blank-check reimbursement to providers. A related problem is the mountainous burden of recordkeeping that our present third-party payment system imposes. Your proposal also provides a way of minimizing this burden.

A majority of Americans, regardless of ideology or party, shares the belief that access to health care is a basic human right. That, Mr. Chairman, I think is a fundamental consideration that has to be kept in the foreground together with the problem of cost. Neither one can be addressed by itself and produce a result that I believe would meet the needs, indeed the requirements, of the American people.

Back in 1971, when I appeared before you, Mr. Chairman, on the proposal we submitted then, I thought that what the Nixon administration had put forward, in its emphasis on a public-private partnership, offered a pragmatic, conservative, and a nonpartisan way of making this right a reality.

If we had agreed then, Mr. Chairman, perhaps legislation might have been enacted. In any case, I believe that what was said about our proposal then, that it was pragmatic, conservative and nonpartisan, can fairly be said now about the remarkably similar proposal that you and your colleagues have put forward. I hope that members of both parties will work with you and others in the Congress to pass legislation that builds on the approach you have proposed, an approach that merits the support of Republicans and Democrats alike. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Your final comments remind me of the old story that Russell Long used to tell about the parish in northern Louisiana that was looking for a geography teacher. Half the school board thought the world was flat and half thought it was round, and you needed a two-thirds vote to be the geography teacher.

There were three applicants. The first one went in and come out, and the other two asked, "Have you got it?"

He said, "No."

They asked why, and he said, "Because I said I teach the world is round."

So the next one went in and came out, and they asked him did he get it, and he said, "No, because I teach the world is flat."

The third one went in and come out, and they asked him whether he'd gotten the job, and he said, "Yes, I did."

They asked, "What was your answer?"

He said, "I can teach it flat, or I can teach it round."

At this time in my life, I'm prepared to teach health care any way we can get a practical solution to it that is going to work and deal with the basic and fundamental challenges of access and also cost containment. That is really the crisis.

Secretary Richardson and Secretary Califano, you have the unique set of circumstances where the providers, the business community and the consumers all understand that the current system is not working, and they have differing views about how to deal

with it. The real challenge today is to try to find in that kind of climate and atmosphere, given the great human tragedies which are occurring daily and will continue to occur, to try to find common ground. This is hopefully a constructive effort to try to do so, building on the shoulders of many individuals including Secretary Richardson, Secretary Califano and others in our attempt to try to get a really significant and useful proposal.

Just to come back to a couple of the points that have been raised, and constantly raised, there are those who say we can't really have health insurance until we get effective cost containment. That is troublesome to me because in effect it is holding hostage the millions of Americans who have no coverage or lose it—today, tomorrow, or over the period of time.

So there has to be a combination of access and also effective kinds of cost control. And I think there has to be a shared burden. Given the financial realities of the Federal Government and State Governments and the business community, if we're going to deal with this, it has to be a shared burden, including the participation of the individuals covered.

In trying to reach that balance, the comment that is made is that it is particularly onerous and burdensome in terms of some of those elements, particularly as regards the business community. I have just a few questions, and I want to make sure that the record is complete on this.

Do both of you agree—having addressed this issue at different times over the past 20-year period—that we have a more deteriorated situation than we had when both of you were in responsible positions and guiding Presidents in health care policy? That is number one.

No. 2, having given this a lot of thought and attention, in what direction do you think the flow line is moving, and how troubled are you about that direction?

We'll follow a ten-minute rule, and we'll start off with Secretary Califano.

Mr. CALIFANO. I think the situation has, as Secretary Richardson indicated, deteriorated significantly. The number of Americans without health care insurance has gone up dramatically by about 30 percent just over the last 10 or 15 years.

Second, we are pouring more and more money into our health care system and getting less and less for it. Since I was Secretary, Medicaid has more than doubled, and the number of people covered are about the same as were covered then.

At its peak in the late 1970's, Medicaid covered almost 75 percent of the poor people of this country, and it covered more than half instantly when Lyndon Johnson passed it. Today it coverage about 40 percent of the poor people.

While this is going on, Mr. Chairman, our standing in infant mortality has slipped. It never was very good. When I was Secretary of HEW, we were about 10th or 11th. I think we are 22nd or 23rd today in the world in infant mortality, and our standing among other nations of the world in life-expectancy is slipping as well. So something is clearly out of sync, and I think the system is, to use the vernacular, more screwed up than it has ever been since I have been working with it.

The CHAIRMAN. Secretary Richardson.

Mr. RICHARDSON. I agree with the points that Secretary Califano has just made. I would add that the considerations of equity are more powerful by a long shot than they were 20 years ago.

One of the distortions that gets into the discussion of this subject derives from the use of averages. This reminds me, Mr. Chairman, of the old definition of a statistician as a man with one foot on a bed of hot coals and the other in a bucket of ice, saying, "On the average, I'm fine." [Laughter.]

While it is said that we have the world's highest per capita health care costs and yet we fail to meet international standards in various respect, including maternal and child health, we're really talking about a number that derives form the overutilization, or at least the luxurious use of health care services by those who can afford them. We meanwhile avert our eyes from the situation of those who cannot.

I think this fact is the reason why we cannot avoid finding a way of reaching the growing numbers of those who do not have access to adequate health care, who cannot afford it, who are uninsured or otherwise unable to pay. And of course, this is what takes us to the use of government.

If the private sector could do it, if market forces were enough, they would have done it. The trend lines were up in 1971. They have been going down, as this committee is well aware. The result then is that the use of government, as I said in my testimony, can only be conceived of so far as I am aware in one of the two ways mentioned—either a comprehensive government plan or one that proceeds through a requirement imposed on employers wherever that is possible.

We have not hesitated to impose similar requirements on employers of many other kinds—workmen's compensation, the minimum wage, the obligation to collect withheld income taxes, Social Security taxes, Medicare contributions.

I see nothing horrendous about saying to employers that they must assure the availability of health insurance as well.

I might add, Mr. Chairman, that apropos the cost dimension, many of the costs that are now accumulating and becoming increasingly burdensome to employers would be diminished by the very fact that there was a mandate. Just to take one, the problem of cost-shifting, which has been estimated as bringing about a 10 to 15 percent higher cost of health insurance for the employers that do provide it than they would pay if health insurance were available to those who do not now have it.

The same can be said with respect to other problems that your proposal would address.

The CHAIRMAN. Mr. Secretary, let me get to the question of cost containment. We heard earlier the ranking minority member talking about a too heavy kind of hand in terms of cost containment; others say it is not strong enough. What is your own assessment as to the appropriateness and the effectiveness of the cost containment provisions of the legislation?

Mr. RICHARDSON. Well, I think, Mr. Chairman, that some of the elements of what has been proposed are clearly useful—among

them, the comparison of utilization so as to cut down on unnecessary procedures of one sort or another.

The CHAIRMAN. You are satisfied in your own review of the various provisions taken cumulatively—and you talked about these in your previous answer in terms of insurance market reform, administrative costs, the negotiation with the national panel—you are satisfied that, taken together and collectively, this can have an important and effective impact in terms of reducing the increases, I imagine—that's what we've got to begin to measure it by—in terms of cost.

Mr. RICHARDSON. Yes, I believe it can, Mr. Chairman.

The one element of this proposal that I would certainly want to have an opportunity to look at much more closely if I had direct responsibility for the follow-up of the process you have launched is the role of the Federal Health Expenditure Board. I think there are problems of seeking to introduce what amounts to the establishment of universal rates, for the reasons that Senator Hatch touched on. We tried that back in the early Seventies, and it didn't work very well, but even if that were totally left out, there would be contributions to cost containment through outcomes of research, development of practice guidelines, technology assessment, which I think are clearly constructive measures.

The CHAIRMAN. Secretary Califano.

Mr. CALIFANO. Mr. Chairman, I guess I think, one, the tremendous increase in the investment in what works and what doesn't work is worth literally billions of dollars. If I had to put a number on it, I think we're talking about as much as $50 billion in health care savings—and especially when you combine it with your proposals with respect to malpractice, to encourage the States to do what California has done.

We know now that in California, for some hospitals and physicians, malpractice rates are rising at a much lower pace, and for some indeed they have remained the same for the last couple of years. So to encourage other States to adopt reforms there will be very important. The premiums may cost only $7 or $8 billion a year only, but the defensive medicine that goes with them is at least $20 billion a year. And doctors don't want to run those tests. It is better care for our people when they don't have to.

With respect to the paperwork problem, all you have to do is stop and think of the fact that in just the last 5 years from 1986 to 1990, for this year, the administrative cost to our system of paperwork has gone from about $63 billion, and as I said it will top $100 billion this year.

On the Federal Expenditure Board, I realize it is difficult, as Secretary Richardson says, to deal with this rate of pay problem, but the one thing we know is the way we are dealing with it now is a disaster for our people. Poor people can't get care even when Medicaid authorizes it, because many States pay doctors so little and hospitals so little, they lose money on the care.

So we are building day by day, hour by hour, a second-class health care system in this country, depending on how much money you have in your pocket.

Second, private payers of good insurance plans, the big industries in this country—communications, electronics, automobiles, and so

on—are paying, as Secretary Richardson said, 15 percent more—I think the Health Insurance Association of America estimates about $8 to $10 billion a year being shifted—than they should pay for that health care.

I'd rather have a system in which doctors are going to be paid fairly and fully for the treatments they provide to people, whether the person they happen to be treating is poor or middle class or wealthy. And I think that will work.

Last, isn't it better to have some kind of a collective board to do this than it is in effect to have one administrator do it, which is what is happening today? We can see the reaction of the American Medical Association, the difficulties in saying this doctor is going to get $5 more, this guy is going to get $3 less. I'd rather have it done in a more thoughtful process.

Finally, the reality of the world is that I think business will welcome this because what has happened on the shifting is they can't keep up with the Federal Government. They can't keep changing what they are paying doctors as fast as the Feds do. And to have a universal plan may be a big help here.

The CHAIRMAN. My time has just about expired, but just a comment in response to what the insurance companies say. They say, "Let us do the job with managed care, working through business, and we'll solve it through managed care."

What is your reaction to that?

Mr. CALIFANO. Mr. Chairman, as you know, I have been chairman of the health care committee of the board of Chrysler for a decade now. We believe we have saved about $2 billion over that period of time, maybe more, in health care costs by managed care. I think we would say that we have reached the limit of our capacity to deal with this problem with managed care. There is a limit. And I think other companies that have tried very hard have reached the limit of their ability to deal with it.

The CHAIRMAN. And it is not necessarily inconsistent with the basic concepts of the legislation.

Mr. CALIFANO. Well, I think the best kinds of managed care would be encouraged by this legislation.

The CHAIRMAN. Mr. Richardson.

Mr. RICHARDSON. I agree with that, Mr. Chairman. I think that managed care should be encouraged. I think the best plans, like the one in the State of Washington, Puget Sound, work very well, and I hope they will be encouraged. But it doesn't follow that they are a panacea, for reasons that Secretary Califano touched on.

The CHAIRMAN. Thank you.

Senator Durenberger.

[Prepared opening statement of Senator Durenberger follows:]

PREPARED OPENING STATEMENT OF SENATOR DURENBERGER

Mr. Chairman, no one has fought longer or harder to make universal access to health care services an essential priority for this country. I commend you and Senators Mitchell, Rockefeller and Riegle for putting health care on the front burner of Congress and turning up the heat.

I am convinced that your "HealthAmerica" legislation will serve as the foundation point for other health access initiatives that will be forthcoming from both sides of the aisle and from the administration in the next several years. And I look forward to working with you, Mr. Chairman, in finding a solution to the difficult and complex problem of access to affordable health care.

Mr. Chairman, a legislative proposal as far-reaching as HealthAmerica holds out a great promise to the American people—universal access, insurance reform, rewriting Medicaid, just to name a few. But to make good on that promise, we need to level with the American people. We cannot have costless universal access. Yet nowhere in the proposal have I seen a cost estimate for the business community, or a tax schemed to pay for public financing and subsidies for small employers.

Is it fair to ask Americans to support the goal of expanded access without clarifying the financial responsibility underlying that commitment? I think not and that is one of the reasons that I voted against a similar proposal during last year's Pepper Commission deliberations.

The core of the HealthAmerica plan is the "pay-or-play" employer mandate that we considered in the Pepper Commission. Businesses, and let's be clear that we are primarily talking about small businesses, will have to provide workers and their dependents with the specified minimum benefit package or pay a percentage of payroll into a state insurance fund on their behalf.

Your own state, Mr. Chairman, could not make this approach work, largely due to gross underestimates of the cost of health care coverage in the state-run program. I believe HealthAmerica suffers the same fatal flaw because it fails to come to grips with the explosion of health care costs in recent years.

The average cost of health coverage in America, according to the summary released last week along with HealthAmerica, is more than $3,000 per employee. But the promise of HealthAmerica is predicated on a health insurance cost of $1,680 per employee. Will the American taxpayer have to foot the bill for the difference between $1,680 and $3,000?

My apprehension with "pay-or-play" models extends beyond immediate financing. When employers are confronted with the choice between paying or playing, they will simply make a determination as to which will be less expensive. Employers whose workers are older and less healthy will be most likely to pay, while those with younger, healthier workers are apt to play. The obvious result is that the state-run plan will be burdened with less healthy membership than employer-sponsored plans, leading to greater than anticipated health care expenses and a continual need to raise the tax required to "pay."

Eventually, the inherent instability of the pay-play model will force employers to abandon their longstanding commitment to insure workers and instead dump them into the state plan. In the end, we will get a Canadian system by the installment plan.

Mr. Chairman, I do not have to tell you that the number one problem underlying the burgeoning number of uninsured and underinsured in this country is uncontrolled health care costs. While I am pleased to see that HealthAmerica contains a number of pro-

visions intended to help slow the rate of increase in these costs, the reality is that this task will take far more than the ammunition that HealthAmerica brings to bear. Most of the cost containment proposed in the bill, including minor reforms in medical liability, restructuring the market for small group health insurance, and the creation of a national health care expenditure board to set (but not enforce!) expenditure targets, simply tinker at the edges of a health care delivery system in need of a major overhaul.

The medical liability reform portion of the HealthAmerica bill goes no further than to provide federal funds to study the liability problem. Mr. Chairman, we have enough information about the problems of medical liability to take corrective action. We need to begin to restructure our system to slow the growth in direct premium costs of medical malpractice insurance, to reduce the amount of defensive medicine practiced in this country, and to promote development of alternative methods of dispute resolution within the states. Several of my Republican colleagues and myself, including most notably Senators Hatch, Domenici, Danforth and McCain have proposed innovative programs for accomplishing these objectives.

National health care expenditures already exceed $750 billion and are projected to more than double before the end of the decade to over $1.5 trillion! controlling these costs will require putting an end to the medical arms race, restoring individual responsibility for health, and changing the wasteful way in which health care is currently delivered in this country.

We have our work cut out for us, but I and the American people ought to be thankful that my colleagues have provided us with a good starting place. I look forward to the coming debate, but even more, I look forward to moving past the rhetoric into constructive, bipartisan solutions to address one of the nation's most pressing problems.

Mr. Chairman, thank you very much. Thanks for the hearing. Thanks for bringing back two of the Nation's experts, two people whom I see a lot of and enjoy watching operate in this field.

Just for the record, let me say I am grateful to the Democrats in the Senate, and I think eventually the Democrats in the House, for laying down an agenda—I don't think it is a complete agenda, but at least someone has finally laid down an agenda. As I said last week in the Finance Committee, the Democrats are the majority party around here, and I think we are the majority party down the street, but I think it is very appropriate that the majority party take on the challenge of laying down an agenda for health care reform. And the notion that there needs to be a Republican response to that so that we can have Democrats against Republicans on this issue I think is insane.

As both of you know, I feel very strongly that this is not a political issue, and I don't believe that by laying the agenda out here, my colleague who is the chairman of this committee or anybody else who has been involved in this is politicizing this issue at all.

By the same token, I'm not sure that listening to your testimony helps me deal with what I perceive to be two of the really fundamental issues we need to deal with. The first is access to health care as a basic human right, without further definition. The

second—and I am quoting Elliott, because I regret I was at another meeting, Joe, and I didn't hear your testimony—the second was that if market forces could have done it, market forces would have done it.

The first, access to health care as a basic human right, demands definition because basically we are talking about reforming a medical delivery system, when the real problems are out there in health care. They are everything from environmental health—what we breathe, what we drink, where we live, the conditions in which we live. We'd have a much improved infant mortality rate in this country if we did something about some environmental issues in this country. We'd have a whale of a higher life-expectancy in America if so many black Americans weren't killing each other, not because of environmental health reasons.

Take behavioral health—that's the new buzz word now for mental health, chemical dependency, and everything else. We can go into just the definition of health in America before we even get to medicine, and if we are going to say it is a basic human right, it is something we ought to get about doing.

Then, when you get to medicine, you're going to deal with access to the diagnostic part of the process, to the remedies, to medical technology, to life-sustaining treatment all costs—I mean, what American wouldn't want to keep their mother and father and grandparents alive forever? That's the system we're running in this country.

So I appeal to you for some definition to something that we all want to agree on, that access to health care is a basic human right.

And the second one, Elliott—maybe I should take these one at a time and have both of you respond to them—is the issue of if market forces could have done it, market forces would have done it, because that is the difference between this side of the aisle right now and the other side of the aisle.

I don't think we disagree as much as we seem to disagree on that issue, but that is a crucial issue.

Mr. RICHARDSON. I'd like to take a shot at responding to those points, Senator Durenberger, and then I'm sure Secretary Califano would like to do so as well.

Of course, you are right, Senator Durenberger, in saying that their proposition, access to health care as a basic human right, is insufficient by itself. Clearly, it is necessary to spell out what elements of health care are so fundamentally essential that government should assume some responsibility to assure that they are accessible.

But all hard questions are questions of degree, as I was taught in law school, and the question here is then one of getting at what we think of as essentially basic—what as a matter of fairness should be assured.

Now, I would say that this most obviously applies to acute care. If you need to have a ruptured appendix treated or a broken leg or a brain tumor, the availability of good, highly-skilled professional care should not depend on the ability to pay.

Now, the kind of package mandated in the proposal introduced by Senator Kennedy undertakes to list the basic essentials. It doesn't include dental care. It doesn't include long-term care. It

doesn't even include long-term care as part of the public plan, but leaves that to the existing Medicaid program.

Where you draw the line is always a tough call in issues of public policy. But it would be a long stride forward to accept the proposition that a situation in which the number of those unable to get access and unable to pay for it is growing is an intolerable situation.

As to the role of market forces, if they could have done it they would have done it, here, I think, Senator Durenberger, the most fundamental point that needs to be made is that we are dealing with a good that is not readily responsive to the kind of analysis normally employed by economists. If any of us gets really sick, we want a doctor; we want to go to the hospital, and we want the best doctor and the best hospital we can find. We instinctively feel that whether or not we can go to a good doctor and a good hospital ought not depend on the ability to pay.

The demand for quality health care is as inelastic as a demand can get. And when people see the advances made by medicine over the years which have made it possible to treat conditions that people simply had to endure and suffer before, the demand becomes inexorable.

Just consider procedures like knee replacements, hip replacements, lens implants. You could say, well, none of these are really necessary, and indeed the government-funded programs in other countries probably don't fund many of them, certainly not in people of my advanced years or anything like it. That is one of the reasons why American health care costs are so high. We do not lightly accept triage on the part of the managers of health care. And when you have a lot of ingenious people in the administration of hospital and health care plans of one sort or another, they will find ways of getting reimbursed if there is any human device that can do it. We have seen this over and over again, whether it is diagnostic-related groups or peer provider organizations. And when I say the market would have done it——

Senator DURENBERGER. Elliott, I'm sorry, but I've just had notice that my time is running out, and I guess I'll have to come back on this.

The CHAIRMAN. No; please continue because I think this is very fundamental, and we'll extend the time.

Mr. RICHARDSON. If I could just finish the sentence, and Secretary Califano hasn't had a chance to respond at all. When you have a situation with the massive element of cost-shifting, the results when there are a large number of those who do not have access and so on, the ingenuity and resourcefulness devoted to finding ways of picking up the money get around the devices that the economists are able to invent. These are just some of the reasons why just turning it over to the market cannot work.

Senator DURENBERGER. Thank you.

Mr. CALIFANO. Briefly, Senator, with respect to your first point about what is the right to health care, we have been dealing with that in this country every day. States deal with it in determining what they will reimburse for and what they won't reimburse for, and I think the legislation that is proposed by Senator Mitchell

and the others deals with that question in terms of what the basic mandate is.

I agree with you that it is a whole system we have to look at; there are individual responsibilities. Insurers and the private sector recognize that. You can get health insurance for less money today if you don't smoke than if you do smoke. There are government responsibilities to immunize children—a responsibility government has not fulfilled in the last 10 years, incidentally. And I think that in that sense, access and what you have access to is something we deal with every day in this country.

I would also agree with you that addiction and chemical dependency is a major problem. We cannot solve a lot of problems, including the health care cost problem, without dealing with it. Again, though, there is a major government responsibility there to do a lot more research and a lot more work than they have done.

On the market force point, I think one of the great things about this bill is that it will let market forces work. It leaves the employer the decision to go out, shop for, find out where he wants to get his health care, whether he wants to get it from an HMO, another kind of managed health care plan, an insurance consortium, provide it himself, hire his own doctors. That kind of thing is what we need more of, and it is government—not the government here in Washington, although I will give you a couple examples of that—that really has been inhibiting the market force.

This kind of legislation would open it up. The States, maintaining the complete and absolute monopoly over the practice of medicine for doctors, denies us the efficiencies of modern technology. Nurses can do a lot of things that once only doctors could do. We have to open that up.

Having pharmacists handle every, single prescription is totally unnecessary. Doctors don't write in illegible Latin anymore. Pharmacists don't mix potions and powders—they count pills. Anyone who can read and count can deliver this. There are 1.5 billion prescriptions coming out of pharmacies every year. They charge anywhere from a couple dollars to ten dollars to dispense it, as a dispensing fee. Mail order houses do it for 50 cents. The State can open that up and can let those market forces operate.

With respect to Medicare, Medicare is inhibited by laws that make it difficult for Medicare to go to the lowest bidder on lab tests, to go to the lowest bidder on various administrations of its program. Some of the things that would happen here would open up those forces, and I think that is important.

I would second what Secretary Richardson said about the perverse market forces here. Two examples. We thought when Medicare and Medicaid were passed we needed more doctors. We passed the Health Professions Act, doubled the number of doctors graduating from medical schools, and it increased costs because the more doctors, the more referrals, the more specialists.

And second, in most countries in the world as a coronary bypass operation, for example, became more and more common, the price of the operation went down. It is about one-third in Canada what it is here. It is much lower in Europe than what it is here. In this country, as the coronary bypass operation became more and more popular, the price went up. So we are not dealing with an ordinary

market. But I do think that if you look at the bill that Senator Mitchell and the others have proposed, the concept of letting each employer go out there and buy his own care will be a very healthy thing for the marketplace.

Senator DURENBERGER. Mr. Chairman, I appreciate the responses, and I appreciate your extending the time.

The CHAIRMAN. Go ahead.

Senator DURENBERGER. By way of additional definition, to me the reason for dealing with "access to health care as a basic human right" is because that is what we all hear. That's the demand we get from everyone. And our responsibility here and on other committees in this Congress extends across everything we have discussed from genetic, to behavioral, to acute, to education, and all the rest of it. Everything goes on in this committee. This is The Committee. This is the health committee in the broadest sense of the word.

But when we get to promising things to Americans, it really is critical that this product which is before us in HealthAmerica does not meet the demands of access to health care as a basic human right. It appropriately takes on one part of that, which is trying to make medical care more affordable. But there are so many other things we have to do around this place in order to get to that—and there are so many people out there—to suggest that somehow this is the answer to all those other problems would be misleading.

So I only argue, Mr. Chairman, that we are not going to solve this problem until we can get more agreement on just what it is that we are talking about, and that is why I raised that as a particular issue.

Mr. RICHARDSON. May I make one quick comment, Mr. Chairman. I think it is worth distinguishing between the proposition that health care is a basic human right and the proposition that health is a basic human right. Health is like the pursuit of happiness and is an appropriate thing to have been subsumed in that phrase in the Declaration of Independence. But I think what we're talking about here is more central than that and deals with response to illness, sickness, injury.

The other point I want to make is that obviously I wasn't arguing that there isn't a role for the market. I was only trying to make the point that we have enough evidence, it seems to me, that exclusive reliance on the market is inadequate.

The CHAIRMAN. Fine. Joe, do you have anything to add?

Mr. CALIFANO. No, Mr. Chairman.

The CHAIRMAN. Senator Wellstone.

Senator WELLSTONE. I'm tempted to jump into this discussion we're having, but I won't because I want to try to be very efficient in the 10 minutes that I have.

First of all, an apology, Secretary Califano. I was late—it's a bit of an irony—because my son had surgery, and I was with him in the hospital back in Minnesota, so I came in a little late today. I would like to point this out—I can't resist it—you know, prairie populism, Minnesota-style. As United States Senators, we have a really outstanding health care plan. We don't have a problem with accessibility to humane, dignified, affordable health care. And it seems to me what's good enough for us ought to be good enough for

people in this country. I just have to point that out at the beginning.

Let me also say—and this is by way of commending you, Mr. Chairman—I don't think that there is a more decisive issue in our country. I think this is a decisive question of our time, and I am impatient for change. I was smiling, looking at Secretary Califano, when we mentioned 1971, and I was thinking to myself I'm a freshman Senator—and I mean this in a positive way, Mr. Chairman, and not at all in a negative way—I would not want to be here 20 years from now with the same moving picture. We've got Kurt and Lee Homan here from Minnesota. They can talk in personal terms—in personal terms—about what all these statistics mean. I don't want to get too much in the abstract. I am impatient for a public policy that will make a difference in the lives of people. And if there ever was a time for us to move forward, it is now.

I want to ask a couple questions. I am completely in agreement with this goal of HealthAmerica for universal access to health care, that it be affordable and it also be dignified and humane care. I have some different ideas about how to reach that goal. I want to work with the chairman, and I am very anxious to be a part of framing legislation.

Let me go to a couple of concerns that I have. First, cost-effectiveness. I agree, I think it was Secretary Richardson who said we've got to both think about health care as a human right—let's not get into definitional problems at the moment—or a citizenship right, or at least this notion of accessibility, but also we have to think about cost control. And quite clearly, you hear from people all across the country that we've got to take steps in that direction.

Now, the GAO came out with a study last week which looked at the Canadian health care system, universal health care coverage, single-source insurance. They said that with that kind of system, we could save $67 billion in this country which then could be allocated for dealing with the problems of those who have no health insurance and more.

There was a study which got a considerable amount of press in the *New England Journal of Medicine*, Steffie Woolhandler and David Himmelstein, where they made a projection of $137 billion with one insurer. Split the difference, and it is still a lot of money.

My question is whether or not you know of a more effective way of actually getting at cost control? I'd like to have some discussion about this report and what it means to you as you think about the direction that we need to go.

That would be my first question for either one of you.

Mr. CALIFANO. On the GAO report, which was talking about administrative costs, I do not think from my experience now that government alone, in one central way, can deal with this problem.

The kinds of concerns I have are, one, just in terms of efficiency, the reality of the way our system works. There are a large number of efficiencies even in the Medicare program. I mentioned a couple before. If all lab tests could be done on a competitive basis—for example, at Chrysler, we said instead of having every doctor send our patients somewhere for lab tests, we'll go out on a competitive bid. The highest bid we got was 30 percent less than the price we were paying to that lab for the tests they were then running. You need

to have a lot of freedom and a lot of buyers in the system, which will be a big plus.

Second—and this doesn't go to your cost point, but it goes to another point that I think is important—I think it is very difficult in a society as pluralistic as our society—and we are far more pluralistic than the Canadians and far larger, with far more varying values—to have one decisionmaker. Just take one issue. Look at what the abortion issue has done in this country in terms of any attempt to get some kind of agreement on it. You want to have a lot of different health plans out there; you really want to have a lot of different States doing somewhat different things. We're going to have that issue 100-fold. We're going to have it with heart transplants. We're certainly going to have it in the area of life-extending equipment and euthanasia. I'd like to have a lot of people making different decisions and not have one person make all the decisions.

Last, I think when you look at the Canadian system in terms of costs, we've all got to recognize one important thing. Prices are much, much lower in Canada—prices for doctors, prices for nurses, prices for hospitals, prices for everything else. And when we say in the auto industry that we want to compete with the Japanese, we don't propose that we reduce the wages of the United Auto Workers because they are paid $30 or whatever it is an hour, and the Japanese are only paid $11 an hour or whatever it is. We don't go about it that way. We want to keep everybody's quality and standard of living. And I don't think the way to provide more health care is to reduce what we are paying doctors, for example. We have seen how that works adversely with respect to the Medicaid program.

I think the bill that is here—no bill is perfect; the area is so complicated, and you know that as well as anybody here—does provide tremendous cost savings, cost savings that I think will exceed what the GAO supposed. The biggest bucks, in my judgment, are in defining what care works and what doesn't work. There are enormous dollars in that, more than the $60 billion.

On the administrative side of one form, one insurer, sure, there are billions of dollars to be saved there. This legislation tries to pick up a lot of that by the insurance consortia and by simplifying forms, and probably more can be done.

Senator WELLSTONE. I want to go to Secretary Richardson. I don't want to debate this, and I want to come back to this particular HealthAmerica proposal. But just for the record, when, Secretary Califano—and I think, Secretary Richardson, you talked about this, too—when you talk about the lack of diversity and this being a pluralistic country, and we have to be very aware of that, I agree. Now, the Canadian model, I don't think you can lump in with all the other European systems. My understanding is it is decentralized through the provinces, and again, from looking at the GAO study I just want to point out it is all within the private sector, by and large, and consumer choice, people decide. So your concern is that there be just one insurance company—you are concerned about that part, not the providing of the health care—is that correct?

Mr. CALIFANO. I'm saying there should be a lot of decisionmakers out there once you get beyond the basic care, and that is a very important piece of the health care system in a pluralistic country.

Senator WELLSTONE. Do you think that we can go further with the cost containment part in HealthAmerica? The question was asked of the two of you before. For example, right now, the rates are advisory—what about the Health Expenditure Board actually having the power to enforce proposed rates? Wouldn't that take us a little bit further down the road of real cost control? I keep focusing on this because I think this is going to be one of the real issues with this legislation, the cost containment.

You're shaking your head no, Secretary Richardson.

Mr. RICHARDSON. Well, price controls have never held costs down for any length of time. You either keep adjusting the official price to keep up with the factors increasing costs, or you don't. If you keep adjusting the price, you have not held it down. If you don't adjust the price, you create a black market of some form. The pressures will get around the ceilings. This is what has always resulted in the abandonment of the effort.

In a war, you can get a substantial degree of compliance for a significant period of time in the name of the patriotic sacrifice demanded by the way.

On the other point, the Canadian plan, as I said in my testimony, we looked at that in 1971 when we were weighing the question of which way to go, and the reason we didn't propose it was essentially the ones given by Secretary Califano just now, and I won't repeat them. We simply felt that it was important to preserve in the system as much as we could whatever competitive factors, opportunities for choice, experimentation, and so on were possible.

We also had in view the point that Secretary Califano also emphasized, namely, the major differences in scale between Canada and the United States.

Finally, I would say that what complicates the problem in the United States as compared, I believe, with any other country is that the attitude of Americans is basically toward wanting now what they want, and wanting the best, and being not likely to be amenable to what amounts in effect to the enforced triage imposed by the Canadian system.

Senator WELLSTONE. If I could just take one more minute, Mr. Chairman. Gee, I thought college professors gave pretty extensive answers, but former secretaries really do. And I want to just follow up, if I could with both of you on the Canadian system, and then I want to go to a question about here and now.

I know that in your testimony, Secretary Richardson you talk about when you considered it that you thought the European or Canadian approach didn't really leave enough room for choice, diversity and experimentation. But the GAO report issued last week pointed out that "Canadians choose their own private physicians. Those physicians are compensated on a fee-for-service basis, and most hospitals are private nonprofit institutions."

So for the people who are here, I just want to draw the distinction between the one insurer, which Secretary Califano has said he is not comfortable with, as opposed to delivery of services, which to my understanding is within that pluralistic framework.

My last question is did you ever think in 1971 than in 1991 we would still be talking about the need for some kind of national health insurance program, and what do the two of you, with your wealth of experience, which I will defer to, believe we need to do to get important and significant health care legislation passed?

Mr. CALIFANO. Let me go back. In 1967, as Senator Kennedy probably remembers, Lyndon Johnson proposed that we extend Medicare to provide prenatal care for women and through the first year of life for babies. That was 1967. We are still arguing about that in 1991.

Second, in March of 1968 he said we have terrible problems with costs in the system; we are tilting it toward hospitalization; we have insurers who are fighting for the healthiest patients, not to provide the most efficient systems; we are paying hospitals on a cost-plus basis and doctors their usual fees. We have to change that. There was no action taken.

I think we have now reached a point where we will see in the next couple of years fundamental changes in the health care system because as I indicated in my testimony, we are going to see not just problems with poor people as we have seen, but we are going to see major medical centers in this country collapse under the existing system. And I think never has legislation been more timely, and this is the time for this country to consider and act on this. And I think it is not a partisan issue, as we've both tried to emphasize.

Mr. RICHARDSON. I'd just like to add a couple of words on the problem of cost containment. It needs to be kept steadily in view that the introduction of methods of squeezing out excessive costs are essentially one-time operations. You reduce the baseline, but you do not eliminate the factors tending toward a continuing increase of cost. That is a point that Dr. William Schwartz of Harvard Medical School has made more than once, and that needs to be kept in view here now.

If you did a perfect job of eliminating unnecessary procedures, operations and so on, you would simply be establishing a new baseline, and from there on the factors of wage increases and new technologies and so on would continue to operate.

The other point I think worth reemphasizing was touched on by Senator Durenberger and Secretary Califano, and that is the importance of preventive measures. This was part of the package that we sent up in 1971. And by the way, Richard G. Darman, now director of the Office of Management and Budget, was on my staff then, and I was pleased to see that he emphasized the importance of prevention the other day in his commencement speech at Bryant College. There is an area of opportunity for government leadership at all levels.

Finally, I would like to just make one brief point. One can go back and back and back to earlier proposals. The significance of 1971 is that that was a Nixon administration proposal. The proposal that we put forward then was a middle-of-the-road, relatively conservative proposal, in competition with the one that Senator Kennedy was then sponsoring. I find it highly ironical that Republicans are attacking Richard Nixon's proposal now. You can draw

your own conclusions as to what it may mean with respect to the ideological shift in the interim.

Senator WELLSTONE. I'd like to thank the two of you. I really appreciate your comments, and I hope I can revisit the question of cost control with you. I'm very anxious to continue that discussion.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Do you have any advice for President Bush?

Mr. RICHARDSON. Well, I wrote an op-ed piece the other day——

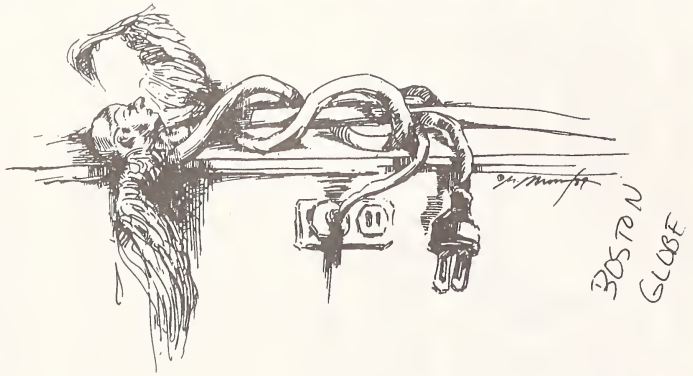
The CHAIRMAN. I have it right here, and we'll put it in the record.

Mr. RICHARDSON [continuing]. Saying that I thought he had a great opportunity to participate in addressing this issue on a nonpartisan basis, and I hope he will.

[The article by Mr. Richardson follows:]

Health-care rallying point

ELLIOT L. RICHARDSON



GEOFFREY MOSS ILLUSTRATION

On what domestic issue should President Bush spend the political capital he accumulated as commander in chief in the Persian Gulf War? Education, crime and drugs have been mentioned as possibilities. But I suggest he do battle against the most vexing social need facing America: the terrible gaps in – and the mounting costs of – our health-care system.

It's the right battle, and he may be the only one able to win it.

Just as it took a president with a strong anticommunist image, Richard Nixon, to open a window of relations with the country we derided as Red China, perhaps only a president better identified with international affairs, like George Bush, can cut through decades of rhetoric and solve our health-care crisis.

The American health system promises the highest quality, most technologically advanced care available anywhere. For all too many Americans, the promise is an empty one. How to fulfill it is an old issue – one on which I have worked off and on for more than 30 years.

As secretary of health, education and welfare in the early '70s, I headed a Cabinet task force on health care. Then, 27 million Americans lacked health insurance. The centerpiece of the task force report was a plan to close this gap in coverage.

Despite our plan, the situation has not improved. Far from it. The number of Americans lacking health insurance is a third higher than it was in 1972. National health expenditures that consumed just over 7 percent of our nation's output in 1970 now devour 12 percent – perhaps 15 percent or more by the end of the decade. Meanwhile, the cost of worker health care, which in 1970 amounted to only about one-third of after-tax corporate profits, had by 1989 equaled them. Most labor-management disputes now relate principally to health care.

The Bipartisan Commission on Comprehensive Health Care, better known as the Pepper Commission, recently looked at this looming crisis. It recommended building on and strengthening our mix of job-based and public coverage.

In arriving at this recommendation, the commission retraced much of the ground that the Nixon administration had covered 20 years earlier. One option considered by the commission was some version of the Canadian governmental-insurance program. We considered the same option. The commission concluded that the takeover of health insurance by government would sacrifice what many believe to be the benefits of pluralism and competition. We reasoned similarly.

In 1991 as in 1971, rejection of the Canadian model left only one practical alternative: to require employers to provide basic protection for employees and their families. The commission chose this approach. So did our task force.

Both the commission and the task force dealt with coverage for the minority of the uninsured who have no connection with a work place. The commission's proposal is patterned on Medicare; the task force's would have expanded the federal-state Medicaid program. Both the commission and the task force called for improvements in private health insurance and special assistance to small businesses having to make health insurance available to their workers. The commission would also give us a start on dealing with long-term care.

The Pepper Commission's plan can fairly be described as conservative, pragmatic and nonpartisan. The same things were said about our proposal. The parallels are striking. They suggest that the factors that produced such nearly identical plans must have considerable force. But the task force plan could not overcome resistance to its adoption. Complaints came from employers not providing worker coverage and insurers fearing some additional degree of regulation or competition.

In addition to these same objections, the commission's plan will meet opposition from some providers affected by its cost-reduction measures. On top of all that, the difficulty of funding the coverage of those with no workplace connection has been compounded by last year's budget compromise, the Gulf War and the recession.

Nevertheless, the case for action is even stronger now than it was 20 years ago. It could then plausibly be argued that the continuing growth of private insurance would minimize the number of uninsured. Just the opposite has occurred. It was possible then for many uninsured families to meet health-care costs out of personal assets. Medical bills now quickly overwhelm most families' savings. At the same time, the very medical advauces that boosted the cost of care underscore the injustice of making access to them depend on the ability to pay. A majority of Americans, regardless of ideology or party, shares the belief that access to health care is a basic human right.

These differences between 1971 and 1991 should lead to a different result. The task force's recommendations have long been gathering dust; that must not be allowed to happen to the Pepper Commission's report. House and Senate committees should schedule hearings on its recommendations. The report should become the rallying point for action in an area where action is long overdue.

And President Bush's leadership would be decisive. By acting boldly to reform America's health-care system, he can make 1991 a "defining moment" in the history of American social policy.

Elliot L. Richardson, the former attorney general of Massachusetts and the United States, practices law in Washington.

The CHAIRMAN. Just a final comment. Talking about this issue, Theodore Roosevelt campaigned on it in the Bull Moose Party; Franklin Roosevelt considered it in terms of social security and then was persuaded to abandon it; Harry Truman, when asked his greatest disappointment as President of the United States, responded that it was failure to enact national health insurance. So the issue has been there. And I think part of the difficulty is not just the complexity but that you have to do it in a macro way; this incremental way of doing it just has not been effective, and that stirs up all kinds of issues.

In conclusion, in the exchange—and I wish Senator Durenberger was here—when you were talking about the market forces, we have attempted to build into this legislation the power of the market forces in permitting, for example, choices in insurance companies, publishing information on outcomes research that will permit purchasers of care to know both costs and outcomes—similar things are happening in Pennsylvania—and employees responsibility for deductibles and copays. So we'd like to believe that there is a reliance on market forces in certain aspects of it, but in other aspects of it, the market forces just aren't applicable, and I think that point was well-made in your responses earlier, but I just wanted to add that.

I want to thank you both very much. It has been very helpful, and we'll be continuing to call on you as we move along.

Mr. RICHARDSON. Thank you, Mr. Chairman, and the committee.

The CHAIRMAN. Thank you.

We'll now hear from a panel of witnesses all of whom have had experience in the growing crisis in our health care system.

I'll ask Greg Hauptman and his wife Joan Conry, from Bethesda, MD to come forward; Kurt Homan and his son Lee, from Plymouth, MN—and I know Senator Wellstone and Senator Durenberger want to make introductory remarks about the Homan family—and Hester Hill from Concord, MS.

Lee, we want to tell you how appreciative we are to have you here this morning, and we hope you are relaxed. We want you to know that you are among a lot of friends here, and we hope you enjoy it because we're going to learn some things from you that we're going to share with our other colleagues on this committee and with the Senate. This is how, hopefully, we'll get some action on legislation. So we are very glad that we'll be hearing from you very shortly.

We'll start off with Greg Hauptman and his wife Joan Conry from Bethesda, MD. I will apologize for Senator Mikulski. She is very actively involved, as you well know, in health policy matters and health issues, and I know she would want me to extend a warm word of welcome to both of you. Please proceed.

STATEMENTS OF GREGORY HAUPTMAN AND JOAN CONRY, BETHESDA, MD; KURT HOMAN AND SON, LEE, PLYMOUTH, MN; AND HESTER HILL, CHIEF, ONCOLOGY SOCIAL WORK, BETH ISRAEL HOSPITAL, BOSTON, MA

Mr. HAUPTMAN. Mr. Chairman, members of the committee, thank you for giving us the opportunity to speak to you today. We

have submitted some written remarks for the record. We hope at this point to just summarize those remarks for you.

We are before you as examples of how the current commercial health care insurance system does not work and does not protect families who are facing catastrophic illnesses of one of their family members.

Our youngest daughter Leann, who will be 3 years old next month, suffers from osteopetrosis, a rare and usually fatal bone disease. In the course of her treatment, she has undergone a bone marrow transplant, she has endured numerous surgeries and other medical procedures, and has spent approximately one-half of her life in an intensive care unit of an acute care hospital.

One would think—and we certainly believed when Leann was initially diagnosed—that we would be better able than most to cope with that problem. My wife and I are both professionals. I am an attorney. My wife is a pediatric neurologist at Children's Hospital here. We have dual incomes. We had the ability of having not just one, but two, insurance policies to cover us and Leann, which provided us with an aggregate of $2 million in lifetime benefits.

Yet in the face of all of that, we have been unable to meet all of our medical expenses. Our medical bills—which are contained in this box here—to date have left us——

Senator WELLSTONE. Excuse me—that whole box is filled with bills?

Mr. HAUPTMAN. Yes.

Senator WELLSTONE. Why don't you hold it up so we can take a look at it, and you might want to show people in the audience.

Go ahead.

Mr. HAUPTMAN. As a result of these bills, we have exhausted the $2 million in our lifetime cap that is available under the two policies and are at the moment facing approximately $265,000 in what may ultimately prove to be uncovered costs.

We are in this predicament because we believe there are four major problems with the current commercial health care insurance system today.

First, we believe that no cap should be appropriate in the face of a catastrophic illness. Too many policies have caps that don't begin to cover the costs involved in medical treatment, and too often those caps, even in the more generous policies, are quickly exhausted. Treatment should be based on medical needs and not on the dollars available from an insurance policy.

Second, even among the better policies there are significant gaps in insurance coverages that preclude many insurance carriers from paying even up to the caps. In our situation, when Leann finally became stable enough to bring home from the hospital, we found that even though we had not exhausted the lifetime cap on either policy that we had only 3 weeks of benefits for home care, skilled nursing, and other medical expenses.

The insurance carriers insisted on implementing and limiting reimbursement on the basis of those provisions, even though the cost of keeping Leann at home was approximately one-half of the cost of keeping Leann in the intensive care unit at Children's Hospital. I was not until we threatened to put her back in the hospital and sue each of our carriers that they finally relented and continued to

pay for our home care benefits until the lifetime caps of our policies were hit.

Third, coordination among commercial insurance carriers and among the government agencies that may pick up from the insurance carriers in some instances is very poor and seriously lacking. Bickering between our two commercial carriers resulted in delays of over 18 months in reimbursing health care providers for expenses that were covered by one or both of our policies resulted in our being turned over to collection agencies not for uncovered costs, but for costs which were covered by our insurance policies.

We had a very difficult time making the transition from our commercial insurance once it became exhausted to the Medicare Model Waiver Program for which Leann was fortunately eligible. Even though we continuously monitored the process and asked our private carriers to notify us when they thought we were approximately 60 days from exhausting our benefits, both carriers notified us that we had run out of our benefits after we had run out.

Similarly, when we tried to prequalify for the Model Waiver Program, we were told that until our insurance benefits were about to run out, we could not be certified for eligibility, and once we were finally certified as eligible, reimbursement was not retroactive; it would only be prospective, running from the date of eligibility on. As a result, we found a gap of over $50,000 in home care expenses which neither our private carriers nor the model waiver program were responsible for and which we are now faced with trying to find a way to repay.

Fourth, the eligibility criteria for Medicaid and the Model Waiver Program are very strict. In most cases they require families to totally exhaust their financial resources before they can be eligible. Leann was fortunate enough to qualify under one exception that does not require that, which is the "emancipated minor" exception. That only applies to a handful of children. It requires that one be hospitalized in an acute care facility for at least 30 consecutive days. Last December, Leann was unfortunate enough to have had a brain hemorrhage that required her hospitalization. The only thing good that happened to us as part of that process was that that hospitalization happened to coincide with the exhaustion of our private commercial insurance benefits. But for that fortuitous event, we would not have been eligible for the Medicaid Model Waiver Program at all, and the $265,000 in expenses that we are facing now would have possibly doubled or tripled.

In conclusion, we hope that Congress in addressing this legislation will keep in mind the plight of families like us, who are facing catastrophic illness of one of our family members.

What is important to remember is that Leann and my wife and I are not at all unique. Catastrophic illness can occur to rich and poor, professionals and blue-collar workers alike. My wife in her practice sees patients like Leann on a daily basis, and families that are faced with the situation that we are facing on a daily basis. Most of them are not as able to cope with the process as we have been.

We hope that Congress will recognize that those who are unfortunate enough to have children with catastrophic illnesses should not be forced to lose all of their financial resources in order to

obtain treatment or be forced with the awful choice of having to deny treatment to a loved one.

Thank you for your attention.

[The prepared statement of Mr. Hauptman and Dr. Conry follow:]

Prepared Statement of Mr. Hauptman and Dr. Conry

Mr. Chairman and the Members of the Committee: We thank you for giving us the opportunity to speak before you today. I am an attorney in private practice in the District of Columbia. My wife is a pediatric neurologist, who has been on staff at Children's National Medical Center since 1983. However, neither of us is before you today in our professional capacities. We wish to describe how the catastrophic illness of our child has left us with hundreds of thousands of dollars of outstanding medical bills, despite very good commercial insurance coverage and the availability of certain Medicaid programs.

We have three children. Our youngest daughter, Leann, will be 3 years old on July 24. She has a rare disease called osteopetrosis, a congenital metabolic disease which affects the osteoclast, a cell in the bone formation process. Osteopetrosis is usually fatal, and the only effective treatment known at this time is a bone marrow transplant. The bone marrow transplant procedure is itself very risky, often resulting in death or other very serious long term complications.

Leann was diagnosed with osteopetrosis at 2 months of age. Since then she has had 3 craniotomies, a tracheostomy, several surgical procedures to place deep indwelling intravenous lines, many bone biopsies, and a bone marrow transplant from an unrelated donor. Leann was hospitalized continuously in an intensive care unit from January 1989 through March 1990. Leann has been home since March 20, 1990, with the exception of 3 hospitalizations.

When hospitalized, Leann's costs for a typical day are approximately $2,000 per day, excluding extra charges for any special surgery or other procedures. When at home, Leann's costs for a typical day are approximately $1,000 per day.

When Leann was first diagnosed, we thought that our insurance coverage would be more than adequate. We had excellent coverage for the family through my law firm, with a lifetime cap per insured individual of $1,000,000. However, being cautious people, we decided that we also would obtain insurance coverage for our family through Children's National Medical Center, my wife's employer, which provided us with a lifetime cap per insured individual of an additional $1,000,000.

But even $2,000,000 in commercial insurance benefits has proven to be insufficient. We exhausted our private insurance sources in December of 1990. Additionally, our two combined policies did not cover a substantial portion of our costs even before we exhausted our coverage. We spent thousands of dollars for bone marrow donor search fees and blood tests for potential donors which were not covered. Leann's air ambulance service was not covered, the cost of which was $8,000 one-way. The cost of administering certain medications which were deemed to be experimental was not covered. And squabbling between our insurance carriers delayed payments for some covered claims for so long that we were turned over to collection agencies for expenses which were fully covered.

What makes all of this even more incredible is that we have been much more fortunate than most other families facing a catastrophic illness. Although our savings are now depleted, for the first year we were able to pay for most of the uncovered costs. We were able to persuade two drug companies to provide new medications free of charge. Our primary insurance carrier approved full payment for the bone marrow transplant itself, unlike other carriers that deny all coverage under similar circumstances, or that provide unrealistic caps for such procedures that cover a fraction of the cost of a typical bone marrow transplant.

When Leann finally was medically stable enough to come home, we faced the severely inadequate provisions of our commercial insurance policies for home care nursing. While each of our policies had $1,000,000 lifetime caps, each contained such severe limitations on skilled nursing coverage at home that we exhausted our lifetime home care benefits after only 3 weeks. Even though the cost of keeping Leann at home is only one-half of the cost of keeping Leann in the hospital, both carriers initially denied continuing coverage of home care costs. It was not until we threatened to put Leann back in the hospital, which was not in the best interest of Leann medically or in the best interest of our family, and threatened to sue our carriers, that they relented and agreed to cover Leann's home care costs.

We are also "fortunate" in that by virtue of the severity of Leann's illness, she is eligible for a combined Federal/State of Maryland program which has picked up some of Leann's costs after our commercial insurance ended. Medicaid covered a portion of Leann's hospitalization costs during her last hospital stay in December 1990, and the Medicaid Model Waiver program has covered a large portion of her home care costs since her discharge. But Leann would not have qualified for Medicaid at all had she not been hospitalized continuously for more than a month at the time her commercial insurance benefits ran out. Had Leann not become eligible for Medicaid prior to her discharge, she would not have become eligible under the Model Waiver program, which provides home care coverage for children sick enough to be hospitalized but who can be maintained at home at less cost to the State. Thus, had we not been fortunate enough that Leann was in the midst of an extended stay in the hospital when her commercial insurance benefits ran out, we would be facing certain bankruptcy in the face of costs in the vicinity of $30,000 per month. However, if Leann's condition improves to the point that hospitalization in an acute care facility would no longer be required, she could lose her eligibility under the Model Waiver program, even though she might then still be in need of constant skilled nursing care.

Unfortunately, the Medicaid and Model Waiver programs, as wonderful as they have been, reimburse providers below their cost, resulting in a limited number of providers. They also have left us with tremendous gaps in coverage. The Model Waiver program does not fund retroactively, but only prospectively after admission into the program. Although we had informed both of our insurance carriers and all of our health care providers that we needed to be notified when we were within 60 days of running out of benefits, we received such notice only after our commercial benefits were exhausted. As a result, we have pending charges which exceed $265,000.

In summary, we wish to make the following points:

1. Any cap in lifetime insurance benefits is not appropriate in the setting of a catastrophic illness, and very few Americans even have that much coverage.
2. There are significant gaps in commercial insurance coverage which result in large debts for medical expenses which most families of catastrophically ill patients are unable to repay.
3. Coordination of benefits among commercial insurance carriers and governmental agencies is poor, and families of catastrophically ill patients are often subjected to collection agencies for expenses which should have been covered.
4. The eligibility criteria for many of the Federal and State programs which could be used to help catastrophically ill patients are often very technical and restrictive, which make them unavailable to most families, or require the financial ruin of the family before the patient is eligible.

Thank you for your consideration.

The CHAIRMAN. Well, thank you very much.

I am always amazed at how a family can deal with not just the financial problems but obviously the emotional ones as well during this time. Yours is really a very, very moving story.

There is a $3,000 ceiling and no caps in this legislation. We don't deal with home care, which will be addressed in a separate long-term care bill, which Senator Mitchell hopes to address, but that would effectively have similar kind of relief, hopefully, for you.

We'll come back to questions, which I know the members have.

Senator Wellstone, do you wish to introduce Mr. Homan?

Senator WELLSTONE. Thank you, Mr. Chairman. I'm sure that Senator Durenberger would also like to make an introduction.

I would like to introduce to you, Mr. Chairman, and all who are attending today Kurt Homan and his son Lee. In Minnesota—and I'm not just making this as some trump political statement—I really believe we have done a lot in the health care field. We had a bill that was vetoed by the Governor—I wish it had been passed—for health insurance for uninsured in the State. But there are limits to what you can do at the State level, Mr. Chairman, and I know you are as aware of that as anybody.

What I want to say to Kurt and to Lee and to Greg and Joan after just hearing your statement, is that this is probably the most difficult day I have had in the Senate. I find it very difficult to listen to this because it is just simply outrageous. It is completely unacceptable.

And what I'd like to say to everyone testifying—I was going to just say it for Kurt and Lee, but I have changed my mind as I am talking—is that I really admire your courage in being here. It is not all that easy to lay bare your personal story. And I think the only reason you are here and doing it is because you believe that there is a connection between what you say about your lives and what you are struggling with, and finally are doing something about it here in the United States Congress.

So the commitment I want to make to all of you, not just Kurt and Lee from Minnesota, is that as a Senator from Minnesota I really want to work nonstop to make sure that we pass national health care legislation that will really make a difference.

I would really like to thank you.

Lee, are you okay? It's not too boring, right? OK.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, I thank you, and I thank Kurt and Lee also for being here. It is not easy to do what they are doing. The idea of coming to Washington, DC. is probably a fun idea, but the second thing is that it is really hard to believe that you can be part of making a difference.

But Paul is absolutely right. He hasn't had the 12 years of experience that I have had here or the chairman's 28 years, but there is a reason why the chairman of this committee is the chairman of this committee, and there is also a reason why so many people are asked to come and testify as you do, and it is because you do make a difference. If that weren't the case, all that pain wouldn't be worthwhile. So, believe it, and Paul, thank you very much for arranging that they could be here.

Senator WELLSTONE. I'm pleased to—and I should have thanked you, Mr. Chairman. I really wanted Kurt and Lee to come, and I thank you for granting our request.

The CHAIRMAN. Thank you.

Kurt, we're glad to hear from you now.

Mr. HOMAN. Good morning, Mr. Chairman, and members of the Labor and Human Resources Committee.

My name is Kurt Homan, and this is my son Lee. We are from Plymouth, MN. I would like to discuss with you this morning some of my concerns with the present system of health insurance in place in our country today.

On February 23, 1988, our then 3½ year-old son Lee was diagnosed with acute lymphocytic leukemia. Due to recent changes in my employment, having started a new job, this diagnosis came 5 days prior to the effective date of health insurance benefits that we had signed up under. First we learn that our son has a life-threatening illness, and then compound it with no way to pay for treatment to save his life.

With help from hospital staff, avenues of acquiring health insurance were explored. The most promising was the Minnesota Comprehensive Health Plan. This plan is designed for people who are

high-risk or otherwise uninsurable. Cost is high, but within reach. However, at the time Lee was diagnosed, the plan only accepted 15 percent of all applicants with leukemia. I learned that the quota for the year had been filled and was told to try again the next year.

All other avenues of insurance either had no benefit coverage for the disease we were fighting or were at a cost factor that was totally unaffordable to anyone with an income under $100,000 annually.

We were left with three options: Try to pay as we go and see how long we could financially sustain; go on welfare and medical assistance and see how long we could financially sustain; or, let our son die because we could not afford the treatment.

To date, over $300,000 has been expended in sustaining Lee's life.

Upon learning of my son's illness, I called my employer to take some time away from work. Three days later, when I went to the business place to arrange my status with my employer, my replacement was already working in my place. It became evident to me that my duration of employment with this employer would end before any pre-existing condition change in the health insurance benefits package came to pass. My employer was self-insured.

I resigned from my job and placed my family on welfare and medical assistance. I felt I had no choice. This was what everyone wanted—the county social worker, hospital social worker, and hospital administration all had told me this was what I had to do.

At the present time, Lee is considered uninsurable by today's underwriting procedures. The job opportunities are very few in which health benefits can be acquired, all of which I am considered unqualified for. I had spent 16 years in professional automotive sales and sales management. Staying in that profession guarantees me the right to never have health insurance benefits for my son.

To reenter the workplace in a job that will provide benefits for my son, I will have to reenter college for two to 4 years to finish my degree work. This means remaining on public assistance—a prospect that we are not looking forward to.

We are fortunate that we have been able to keep our very modest home. It has not been easy. We are presently in bankruptcy. We have had to beg for assistance from private agencies. We have borrowed money from friends and relatives just to meet the monthly bills.

I am still trying to figure out how to stretch one dollar into three.

Our family at this time is never much more than 1 month's payment away from joining the homeless of America—all due to unaffordability and unavailability of health insurance coverage.

I am able and willing to actively pay into the system. However, the system itself prevents me from doing so.

At the present time, Lee is 6½ years old, in generally good health. His leukemia is in remission, and he just completed chemotherapy 2 months ago. We pray and hope that Lee's remission will be permanent. For 30 percent of leukemia victims, it is not.

There is a great need for reform of the health insurance industry in this country. It is my sincere hope that reform can be accomplished so that other families no longer will have to endure anything like we have through the last 3 years.

Something is wrong when a family must go on welfare to obtain health insurance. My family is only one of literally thousands of families in this country that has had to do so.

Thank you for this opportunity to talk to you and for hearing what I have had to say.

The CHAIRMAN. Thank you, Mr. Homan.

Lee, how are you doing today?

Lee HOMAN. Fine.

The CHAIRMAN. Are you glad to be here with your daddy?

Lee HOMAN. Yes.

The CHAIRMAN. Is this your first time to Washington?

Lee HOMAN. Yes.

The CHAIRMAN. Do the other members of your family wish they were here, too?

Lee HOMAN. Yes.

The CHAIRMAN. You'll tell them all about it. We are glad you are here, and we appreciate it very much. I'm sure everything will work out well.

Ms. Hill, we're glad to have you here, and we look forward to your comments and testimony. I know of the good work you do as chief of oncology social work at Beth Israel Hospital, one of our fine hospitals in Boston. I had the good fortunate to talk to the oncology nurses' convention a couple of years ago with Mrs. Quayle, who made a very important and I thought impassioned statement about the importance of testing and the preventive aspects of health care dealing with cancer and women.

We look forward to your testimony.

Ms. HILL. Thank you, Senator Kennedy. Thank you also for the promotion. Unfortunately, I am the chief of oncology social work—I wish I were the chief of oncology—at Beth Israel.

It is a particular pleasure to speak to this particular audience. I obviously am a Massachusetts resident, and my older daughter is a student at Macalester College in St. Paul, so some other reputations have preceded you all to this room.

I have worked in oncology social work at Boston's Beth Israel for the last 12 years. Additionally, I sit on the board of directors of the American Cancer Society, Massachusetts Division; the Massachusetts Initiative for Cancer Pain, and numerous other committees which focus their efforts on trying to meet the needs, primarily the psychosocial needs, of cancer patients and their families.

My world view, especially as it relates to health care, is grounded in the traditional social work values of equality, of justice, and of giving of our hearts and responding to what we feel in our own souls.

I come here today to speak for the thousands of Americans who, facing life-threatening illness, are forced to contend also with inadequate medical insurance coverage, with limited options, with catastrophic financial problems at the very moment when they most need to focus their energies on getting well again.

I come today to speak to you of hope—of hope for quality care for all Americans, of hope for life, and of hope in the belief that this starting today is our opportunity to make a change.

I am too well-acquainted with grief. From my vantage point in the trenches, I observe each day the unnecessary anxiety and pain

and worry experienced by people who discover that the safety net is full of holes. Problems range from outright denial of coverage for some potentially life-saving treatments to enormous copayments to whole families losing their medical insurance when the breadwinner, who has a pre-existing condition, is unable to buy even a basic medical insurance policy.

The numbers of people so affected are ever increasing in these difficult economic times. A worker who is laid off eventually exhausts his COBRA benefits for himself and his family, and new jobs and new medical insurance possibilities are scarce.

Let me briefly describe a few specific situations I have known about in just the last few months.

I think first of a young mother with breast cancer whose cancer recurred very quickly following her standard radiation and chemotherapy treatments. Always a devastating scenario, this one was exacerbated by both emotional and practical features. Her cancer had been initially diagnosed when she was 7 months pregnant. Balancing the simultaneous joy of a new life and the terror of losing her own had been extraordinarily stressful for her and her family. She and her husband used this time in a growth-enhancing way to reconsider their life priorities, to rethink what they did with themselves. She chose from then on to stay home with her two young children, and her husband changed jobs, to a smaller company which would allow him to spend more time with his family.

The cost—a minimal insurance policy which excluded his wife from coverage for a thought-to-be-safe waiting period which turned out not to be so safe.

I think of a 28 year-old Lebanese man who came to our great country 10 years ago, fleeing the war and devastation in his own homeland and joining his future to our country's dreams. His plans and his hopes were shattered by his recent diagnosis of lymphoma. Symptomatic and very ill for some months, he delayed coming for treatment because he had no insurance. By the time he came, too weak and too sick to stay away any longer, to Boston's fine City Hospital, where care is offered to all of our citizens, his disease was quite advanced.

At this moment, he is holding his own, but certainly, most certainly, earlier medical interventions would have greatly enhanced his chances for cure.

Finally I think of a 60 year-old grandmother who had been a solidly middle class woman, a brave and adventurous soul who, following a divorce and the departure of her youngest child from home, moved to Israel to follow her dream. While there, she was diagnosed and treated for colon cancer. When her cancer recurred a year or so later, she returned to Massachusetts, her own homeland, to be with her family for her dying.

She expected and received her family's love and support. What she did not expect was the absolute impossibility of purchasing any medical insurance. Who would pay for her palliative radiation? Who would pay for her many doctors' visits, for her expensive pain medications, eventually for her home hospice care?

In closing, if this is my five minutes as an ordinary citizen, as a social worker, as a daughter and as a mother, to raise my voice in these halls of power and of influence, let me raise it to plead with

you to remember our brothers and our sisters who walk with grace and with courage and with dignity, who take on, often without complaint, heroic battles for life and who must be given in this country the opportunity, the hope and the chance to go on living, the chance that can come only with equal and open access to equal and human medical care.

Thank you.

The CHAIRMAN. Thank you very much for your excellent statement.

The answer ought to be obvious, but I'm going to give you a chance to explain it in your own words. What do you say to the political leaders who say that we have to wait to develop a consensus; that now is not the time to deal with this issue; that it needs more study? I'd like to hear from each panel member.

Dr. CONRY. We have waited for many, many years. In 1971, when legislation was initially attempted, I was a sophomore in college. I was a rider on my parents' insurance policy. I don't want our other two healthy children to be faced with this 20 years from now. Health care will not bear the cost of it.

I am a physician. I am on both sides of this argument in terms of cost containment and costs and necessary tests, and many of the things that have been done to our daughter were unnecessary costs; there were duplicate billings; there were unnecessary administrative costs, which is simply outrageous. Services were not available locally that could have been provided locally, necessitating air ambulances. Air ambulances between here and New York cost $8,000. I mean, you can buy a lot of health care for $8,000.

We have to have reform or I'll have no job.

Mr. HOMAN. I guess my main question is to the private insurance carriers. You keep hearing the private insurance carrier lobbyists or whomever saying that they're not making any money in health care. Then why do they want to stay in that business so badly?

Senator WELLSTONE. Gee, that's an interesting question.

The CHAIRMAN. Ms. Hill.

Ms. HILL. I would just ask anyone who is brave enough to open her heart to walk with me for a day.

The CHAIRMAN. Very good. Senator Wellstone.

Senator WELLSTONE. I have two different questions. One, for Greg and Joan and Kurt and Lee—did you ever think that what you have talked about here today with us would ever happen to you; and what do you think the lesson is from your lives about health care in this country and for middle America?

Mr. HOMAN. First of all, you never expect to be hit with a catastrophic illness. Everybody thinks that is going to happen to somebody else. So when it happens to you, it is something that is totally unexpected to begin with. I'm a believer in the fact that everything has a purpose, and like I was discussing with my wife before I flew down here the other night, perhaps the good Lord's intention of having us go through this with Lee was for me to raise my voice and get involved. So maybe that was the purpose behind it; I don't know.

Senator WELLSTONE. Well, you have certainly raised your voice here today. Dr. Conry.

Dr. CONRY. We obviously didn't think it would happen to us. One of the reasons that we wanted to be here is because we are perceived—and we are very lucky; in many parts of our lives, we are very lucky—but we still have a child with a catastrophic illness and are in a situation where we are potentially going to be financially ruined.

When you said your son was operated on, I don't know what happened, and God knows, I hope he is healthy, but you have great insurance in the Senate. There is no such thing as great insurance when you have catastrophic illness because it snowballs, and you find yourself making decisions about is it ethically right or not right to provide medical intervention, and if it is ethically correct, can you afford it. The two issues start getting tangled.

In noncatastrophic illness for "elective" medical treatment, you can discuss decisions, but in the setting of catastrophic illness you are faced with questions that there are no answers for.

Senator WELLSTONE. People will say, "Paul, you are obviously asking a leading question," so let me just say I am asking a leading question. There is going to be all this debate about too much regulation and what we're going to do about cost control and private market and is this an appropriate role for the government to play.

What is the message from your personal experience? Kurt said that he—I hope this is okay if I take your words; they were personal words, and if I am going astray here, you tell me—you said you were talking to your wife and you said to her that maybe it was meant to be that you are here, being a voice for change. What is the message to middle class America that comes from your personal experience? As we now go into this debate, and we now try to frame legislation, what is the message from your experience that goes far beyond your personal experience to middle class America about health and what we need to do?

Mr. HOMAN. Well, I think in a nutshell it boils down to that the system that's in place right now does not work. We've got a broken wheel, and we've got to fix it. The old adage goes, "If it's not broken, don't fix it," but this is definitely a broken wheel.

The CHAIRMAN. If I could just add, it's been pointed out and I've heard, "Well, you can get three witnesses in the United States of America to testify on anything." That's what we've heard for too many years. The fact is, we could pack this hearing room every hour of every day with examples like this.

I can remember being up at Children's Hospital when my son got the experimental therapy for osteosarcoma, which at that time was about 22 percent chance of survival, and it worked out well for him—halfway through, it changed from an experimental drug to a legitimate drug—but it was $2,300 every 3 weeks. And I would meet the parents outside the rooms and they'd be saying, "Do you think we can get by with it for 12 months?" or "Can we get by with it for 8 months, because we just can't afford it." And to have that kind of decisionmaking going on, which all of you have talked about, is an issue we just have to deal with.

I just want to join with Paul and say I think the best way we can ever thank you for coming here is to keep on keeping on, and I have every intention to do so, and I know Senator Wellstone will as well. Thank you very, very much.

Senator WELLSTONE. Thank you.

The CHAIRMAN. Our final witness is Sal Risalvato. Mr. Risalvato is a small businessman and is here speaking in behalf of the National Federation of Independent Business.

I recently appeared with him on the McNeil-Lehrer News Hour with Senator Hatch, and it is nice to see him again. We're glad to have you here.

STATEMENT OF SAL RISALVATO, RIVERDALE, NJ, ON BEHALF OF NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Mr. RISALVATO. It's good to see you again, Mr. Chairman.

Obviously, we've got a very difficult balancing act that we have to do here. We do have a problem, and we have to take care of it.

I'd like to personally thank you, Senator Kennedy, for inviting me.

The CHAIRMAN. How did our pictures come out?

Mr. RISALVATO. I haven't seen them. Hopefully, by the time I get back, they will be developed. I know that some of the other people who were with me from New Jersey were very anxious to see them.

Again, I would like to personally thank you for inviting me here to give the side of small business.

You have my statement. I am going to try to trim it a little in the interest of time. I'd like to make note, though, that in the back of my statement is a letter from our vice president of Federal Govrnment relations, Mr. John Motley, and I'd like that to please be ɔfficially entered into the record.

The CHAIRMAN. Your full statement will be printed in the record as it read.

Mr. RISALVATO. Thank you very much, Mr. Chairman.

Again, I would like to thank Senators Hatch and Kennedy for extending the invitation to appear before you so that I may explain the position of the small business community on the topic of mandated health care.

I would like to start by saying that I am a small business owner and that I employ ten people. I have been in business for over 16 years, and I have never been employed by anyone other than myself. For the past 14 years, I have been in the auto repair and gasoline business.

Since 1980, I have been a proud and active member of the National Federation of Independent Business. I am here this morning to speak on behalf of the 500,000 members that belong to NFIB and who voice their opinion through the NFIB mandate ballot.

Obviously, our Nation is facing some pretty tough decisions regarding the availability of health insurance. I applaud you, Mr. Chairman, for recognizing this critical issue and commend you in your efforts to get a national discussion started.

To say that the problem with our health care system is that not enough Americans are covered by health insurance is incorrect. The fact that so many Americans do not have insurance is not the problem; it is the result.

The problem lies in the outrageous cost of health care and the reasons for the outrageous cost. I ask that you take a careful look

at the reasons health care services cost so much and to come up with a solution to reform the cost side of the system.

I myself have provided health coverage for my full-time employees for the past 10 years. When I first started to provide coverage, it was expensive but affordable. I was so happy and proud that I was providing benefits for my employees to protect them and their families. I remember wishing at the time that I could have done it sooner, but I was still very, very happy that I finally had.

I continued with the same carrier for the first 5 years, absorbing a few costly premium increases, but the sting from them was always unexpected, especially since other costs of doing business were not rising as fast.

The next 5 years, though, were not so good. I have replaced insurance carriers three times in these past 5 years. Each time, on the anniversary of the policy, I received a notice that the rate for the upcoming year would be 40 percent higher than the previous year. Of course, rate hikes like that are simply not affordable, so I was forced to search for a new carrier each year—always cutting the benefits and any fringes that went with them in order to make the premiums more affordable.

While my business struggled to maintain its policy, other small businesses were unable to afford health insurance at all. If reforms were started in motion to reduce the cost of health care, then the cost of health insurance would also be reduced. Should the cost of health insurance be reduced, then certainly it will be more affordable to small businesses to provide it for their employees. If also the cost of health coverage were reduced to affordable levels, then more individuals would be able to purchase it for themselves. Of course, this is where the true responsibility lies—with the individual.

Without exploring ways to dramatically cut the cost of health care, there will be no solution. How can we start to cut the cost of health care? We can start by making a determination when we receive our hospital bill how much of the bill is a medical bill and how much is a legal bill. The ridiculous cost of medical malpractice insurance has two effects. First, it directly adds to the overhead of the doctor or hospital; and second, it creates an environment that encourages doctors to practice defensive medicine.

Defensive medicine may include many extra tests and procedures to prevent the doctor or hospital from an appearance of negligence. The absence of the appearance of negligence is needed to keep the sharks that we all know as attorneys from convincing gullible juries that their clients should become instant millionaires.

The second way of reducing cost is to promote consumerism in our health care and consumerism in health insurance. Since patients are really like customers, they should be encouraged to behave like customers and shop like customers. In order to shop, they need to know and understand the products and services that they receive from their doctors.

Consumerism in health insurance is just as needed and just as difficult to understand. Reform should include a means to simplify and explain the difference between insurance policies. Consultants should not have to be hired to figure out the best policy for either an employer or an individual.

Insurance companies market their products in such a confusing manner that it is difficult to compare apples with apples and oranges with oranges. We need to give the consumer a clear, simple, precise plan of options.

One other way to promote consumerism is to have individuals share more in the cost of health care. With higher deductibles and cost participation in any plan that an employer may provide, individuals will be more concerned about holding down costs. As a society, we tend to be more mindful and prudent when we are paying the bills and not very respectful when someone else is paying the bill. The free enterprise system will prevail here if given a chance.

The third avenue to explore cost-cutting measures would be to review health care requirements that each of the States impose on insurance companies. There are many nonemergency, noncritical expenses that insurance companies are required to cover if they offer health care coverage in a particular State. Some simple examples are herbal medicine, in vitro fertilization, and drug and alcohol therapy. There are many others—too many to list. Individuals and small businesses should have the option of choosing coverages in these areas in exchange for lower rates overall.

A fourth remedy for cost increases is the reduction of fraud in the medical system, particularly in Medicaid and Medicare. We have all seen the TV documentaries and news specials that reveal dishonest clinics, doctors, pharmacies and pharmacists. As in any other business, there exists in the world of medicine those sleazy individuals who will choose to take advantage of the system.

The solution for our national dilemma is to allow the free enterprise system to function. Leave business alone. Stop mandating and regulating. Provide us with incentives, not punishments, and we will get the job done, as we have always gotten the job done.

The government has failed in having any prolonged success with any social welfare program, with the possible exception of Social Security, and it has been a hard-fought battle to keep that solvent. The welfare system, food stamps, Medicare and Medicaid have all been rendered a failure. All of these programs started out with good intentions, but are all so ravaged with inadequacies and abuses that they have become an economic albatross to our Nation. I shudder to think of the Federal Government in the health insurance business.

I also shudder to think of the same government telling me how to run my business. I put the key in the door every morning. I decide how much inventory our cash flow allows. I decide who should work what hours and for how much. I decide when a tool or a piece of equipment is a good investment. I sign the check that pays the mortgage and the electric bill.

Rest assured, Mr. Chairman, that the bank will call me if I cannot make my mortgage payment, not the U.S. Senate.

Therefore, Mr. Chairman, I should also decide what benefits and insurance I will or will not purchase.

Small business will be happy to participate in finding solutions to this problem, but please keep in mind that small business did not cause this problem, and small business should not have to be the ones to pay for it.

Thank you very much, and I will answer any questions.

[The prepared statement of Mr. Risalvato (with an attachment) follows:]

Prepared Statement of Mr. Risalvato

Good morning Senator Kennedy and members of this distinguished Committee. I would like to thank Senators Hatch and Kennedy for extending an invitation to appear before you so that I may explain the position of the small business community on the topic of mandated health care.

I would like to start by saying that I am a small business owner and that I employ 10 people. I have been in business for over 16 years, and have never been employed by anyone other than myself. For the past 14 years, I have been in the auto repair and gasoline business.

Since 1980, I have been a proud and active member of the National Federation of Independent Business (NFIB). I am here this morning to speak on behalf of the 500,000 members that belong to NFIB and who voice their opinion through the NFIB MANDATE ballot. I am also an active member of the New Jersey Gasoline Retailers Association, and serve as Vice-President of the Riverdale Business Association in my community. I was elected in 1986 as a delegate to the White House Conference on Small Business from my home state of New Jersey. In short, I am a staunch supporter of the free enterprise system, and a true believer that small business is the foundation that this country is built on.

Obviously, our nation is facing some pretty tough decisions regarding the availability of health insurance. I applaud you, Mr. Chairman, for recognizing this critical issue and commend you in your efforts to get a national discussion started.

To say that "the problem with our health care system is that not enough Americans are covered by health insurance" is incorrect. The fact that so many Americans do not have insurance is not the problem, it is the result. The problem lies in the outrageous cost of health care and the reasons for that outrageous cost. I ask that you take a careful look at the reasons health care services cost so much and to come up with a solution to reform the cost side of the system before you break the backs of the driving force of our nation's economy, the small business person.

I, myself, have provided health coverage for my full-time employees for the past ten years. When I first started to provide coverage, it was expensive but affordable. I was so happy and proud that I was providing benefits for my employees to protect them and their families. I remember wishing at the time that I could have done it sooner, but was still glowing that I finally had. I continued with the same carrier for the first five years, absorbing a few costly premium increases, but the sting was always unexpected, especially since other costs of doing business were not rising as fast.

The next five years were not so good. I have replaced insurance carriers three times in the past five years. Each time, on the anniversary of the policy, I received a notice that the rate for the upcoming year would be 40 percent higher than the previous year. Of course, rate hikes like that are simply not affordable, so I was forced to search for a new carrier each year, always cutting benefits, raising deductibles, and trimming the "frills" in order to make the premium more affordable. Some insurance carriers don't even have the patience to wait a full year, and will only guarantee their rates for six months. Each year for the past three years, I have had to carefully decide whether or not to change the percentage of our contribution toward health care or to even provide it at all. The obscene cost of continuing our policy of 100 percent contribution has been extremely difficult to maintain. One member of my local business community who employs 65 people has told me that he had the same health insurance carrier for 15 years before he too changed carriers three times in the past five years. He even had to hire a consultant to work through the different terms, conditions, and costs for each carrier so as to understand and properly select a new policy. The costs now have gotten so out of hand and unpredictable that he plans to pass any increases in premiums onto his employees. This situation is not uncommon.

While my business struggled to maintain it's policy, other small businesses were unable to afford health insurance at all. If reforms were started in motion to reduce the cost of health care then the cost of health insurance will also be reduced. Should the cost of health insurance be reduced, then certainly it will be more affordable to small businesses to provide it for their employees if, of course, they choose to do so. Also, if the cost of health care coverage were reduced to affordable levels, then more individuals would be able to purchase it for themselves. Of course, this is where the true responsibility lies—with the individual.

Without exploring ways to dramatically cut the cost of health care, there will be no solution.

How can we start to cut the cost of health care? We can start by making a determination when we receive our hospital bill or a bill from a doctor, how much of the bill is a medical bill and how much is a legal bill. The ridiculous cost of medical malpractice insurance has two effects. First, it directly adds to the overhead of the doctor or hospital, and second, it creates an environment that encourages doctors to practice defensive medicine. Defensive medicine may include many extra tests and procedures to prevent a doctor or hospital from an appearance of negligence. The absence of the appearance of negligence is needed to keep the sharks that we all know as attorneys from convincing gullible juries that their clients should become instant millionaires. I wonder if this is highly motivated by the monstrous fees generated from the settlement.

The second way of reducing costs is to promote consumerism in our health care and consumerism in health insurance. Since patients are really customers, they should be encouraged to behave like customers and shop like customers. In order to shop like customers, they need to know and understand the products and services that they receive from their doctors. This Committee should learn from consumer and medical experts just how this can be accomplished.

Last year my nephew was bitten by a squirrel. Nothing serious, it was an accident, the squirrel didn't mean any harm, he was only trying to steal a cookie that was in my nephew's hand and happened to catch a finger. A minor cut was the result. My brother, being a cautious parent and concerned about rabies, took my nephew to a nearby doctor. The doctor spent less than 3 minutes examining the finger, told my brother to put a bandaid on it, and billed him $50. That calculates out to $1000 per hour! That is not uncommon. Most people never ask the doctor how much his fees are, they just pay it.

Recently my sister-in-law, who is five months pregnant, was asked by her doctor to take a urine culture. Twice previously she was pregnant, and was treated by the same doctor without being asked to take a urine culture. Was this necessary? Or was this an example of profit taking? The doctor charged an additional $45 for the urine culture. The bill was submitted to the insurance carrier, so who cares? Right? A further check with another doctor found that his fee for the same urine culture was $15. It all makes you wonder what kind of excesses in costs really exist in the medical industry.

Consumerism in health insurance is just as needed and just as difficult to understand. Reforms should include a means to simplify and explain the differences between insurance policies. Consultants should not have to be hired to figure out the best policy for either an employer or an individual. Insurance companies market their products in such a confusing manner that it is difficult to compare apples with apples and oranges with oranges. We need to give the consumer a clear, simple, precise, plan of options. Don't give the consumer a policy that will nickel and dime you out of the hospital. There should be a commission set up to declare as many as 10 different plans, and each of those plans should be labeled plan A through J, and every insurance company should be required to have the same frills for a plan A as all other insurance companies, and the same frills for a plan B as all other insurance companies, etc. Then apples truly could be compared with apples, and oranges with oranges.

One other way to promote consumerism is to have individuals share more in the cost of health care. With higher deductibles and cost participation in any plan that an employer may provide, individuals will be more concerned about holding down costs. As a society we tend to be more mindful and prudent when we are paying the bills, and not very respectful when someone else is paying the bill. The free enterprise system will prevail here if given a chance.

The third avenue to explore cost cutting measures would be to review the health care requirements that each of the states impose on insurance companies that operate within their states. There are many non-emergency, non-critical expenses that insurance companies are required to cover if they offer health care coverage. Some simple examples are herbal medicine, in-vitro fertilization, and drug and alcohol therapy. There are many others, too many to list. Individuals and small business should have the option of choosing coverage in these areas in exchange for lower rates overall.

A fourth remedy for cost increases is the reduction of fraud in the medical system, particularly in Medicaid and Medicare. We have all seen the T.V. documentaries and news specials that reveal dishonest clinics, doctors, pharmacies, and pharmacists. As in any other business, there exists in the world of medicine those sleazy individuals who will choose to take advantage of the system. Experts should decide

those sections of the system that are most abused, and suggest reforms that will work. Clinics, doctors and even patients that are caught abusing any insurance program, whether it be a private plan or a Medicare/Medicaid plan, should be severely punished.

The solution for our national dilemma is to allow the free enterprise system to function. Leave business alone—stop mandating and regulating. Provide us with incentives, not punishments, and we will get the job done as we always get the job done. For two centuries businesses, large and small, have met their responsibilities and have inspired this great nation to grow.

The thing that bogs down growth and prosperity is government interference. The government has failed at having any prolonged success with any social welfare program, with the possible exception of Social Security, and it has been a hard fought battle to keep that solvent. The welfare system, food stamps, Medicare, and Medicaid have all been rendered a failure. All of these programs started out with good intentions, but all have been so ravaged with inadequacies and abuses, that they are now an economic albatross to our nation. I shudder to think of the federal government in the health insurance business.

I also shudder to think of the same government telling me how to run my business. I put the key in the door every morning. I decide how much inventory our cash flow allows. I decide who should work what hours and for how much. I decide when a tool or piece of equipment is a good investment. I sign the check that pays the mortgage and the electric bill. Rest assured, Mr. Chairman, that the bank will call me if I cannot make my mortgage payment, and not the United States Senate. Therefore, Mr. Chairman, I should also decide what benefits and insurance I will or will not purchase.

If you continue to burden the small business community with more mandates and costs, you reduce the chances for our survival in an already fragile business environment. If small business is not able to survive, then both unemployment and inflation will rise, resulting in less revenue for the federal government and larger deficits than we presently have.

Small business will be happy to participate in finding solutions to this problem, but please keep in mind that small businesses did not cause this problem and small businesses should not be the ones that have to pay for it.

Thank you very much for allowing me to speak, and I will be happy to respond to any questions that you may have.

June 10, 1991

Honorable Edward M. Kennedy,
Chairman,
Senate Committee on Labor and Human Resources
SD-428 Dirksen Senate Office Bldg.
Washington, DC.

Dear Mr. Chairman: On behalf of the 500,000 small business owner/worker members of the National Federation of Independent Business, I respectfully request that this letter be submitted into the hearing record of June 11.

As this Committee is well aware, the number one problem facing small businesses is the rising cost of health care and insurance. It is costs, not cold-heartedness, which limit the access small business owners, their families and employees have to insurance.

To help alleviate this problem for small businesses individuals and the economy in general, NFIB has developed a detailed "Access for Small Business Strategy" which has been shared with this and other committees. This strategy takes direct aim at the root of our nation's health care problems—medical inflation. Only through cost containment can we truly help those victimized by the present system—the individual, the low income family and the small business. Only by focusing upon affordability will expanded access be achieved.

The introduction last week of legislation to mandate health insurance and raise payroll taxes is vehemently opposed by small business owners nationwide. When polled through the MANDATE ballot, over 96 percent opposed increasing payroll taxes to pay for the uninsured and over 90 percent oppose mandated health insurance.

I would add one further reason for opposition to the "pay or play" proposal. It moves implementation of much needed help into the future. Small business owners and individuals need help today. Many of the proposals outlined in NFIB's "Access" plan are points of consensus achieved across a broad range of views and interests.

Some are contained in the new Leadership proposal, many are cited by members of this Committee, all could be enacted if the baggage of mandates, taxes or national health insurance were dropped. These points of consensus tackle the engine driving the problem of the uninsured or so-called underinsured—rising costs. Until care and insurance are affordable, access will always be diminished or nonexistent.

Thank you for the opportunity to restate the NFIB position on health care reform and mandated benefits. As always, my staff and I are willing to discuss NFIB's plans for reform in detail with you and any other committee member.

Sincerely,

JOHN J. MOTLEY III,
Vice President, Federal Governmental Relations

Senator WELLSTONE [presiding]. Thank you, Mr. Risalvato.

I stayed because I really wanted to hear your testimony. I think it was very powerful and important. The chairman had an engagement—I believe he was called to a press conference dealing with the problem of what we're going to do in this country about breast cancer, and he apologizes for having to leave early.

Let me ask you a couple of questions if I can, because I kind of liked the spirit of the way you said things. You were direct, and you were blunt. I share your critique of some of the excesses of cost. There has been a lot of discussion of the medical arms race and a lot of ways in which things could be more cost-effective, and you talked about that.

From a small business point of view, you provide coverage for your employees, and you said that you were very proud of that. And I think maybe it was on "McNeil-Lehrer" when you were on, you said it also, you think, gives you a competitive advantage.

Mr. RISALVATO. Yes.

Senator WELLSTONE. I sort of like the way you put that.

But there are all sorts of other small businesses that don't provide any coverage for their employees, don't feel like they can. So what are we going to do about that? I mean, you say keep the government out——

Mr. RISALVATO. Well, you just ended your question with "they don't feel like they can"—I was just going to ask you do you think that these small businesses do not want to provide this type of coverage?

Senator WELLSTONE. No.

Mr. RISALVATO. A small business owner would prefer to have coverage for——

Senator WELLSTONE. No, I do not, and that's something——

Mr. RISALVATO. What family would not want to be able to have health care coverage for his family? It's very basic. But if you can't pay for something, you can't have it. As with any other business decision I must make before I make a purchase or before I hire somebody, I have to ask can I afford it. If I can't, the thing that gets paid first is the mortgage, the thing that gets paid second is the electric, and the phone, and all of those basic things. If my business cannot afford to provide these benefits, then I have to let something else go, and that may be the employee who was going to receive the benefits.

I don't see that as being an advantage, to have to lose an employee over a benefit.

Senator WELLSTONE. That's precisely my question. You ask me, well, Senator, do you think the reason small businesses don't provide the coverage is because they don't want to provide coverage for their employees. I come from a small town in Minnesota, and if I didn't know it before—let me just admit to you, I don't own a small business, and next to actually owning one, which is how you really learn, living in a small town where you really come to know people as friends over the years, you get a real sense of what they are faced with. I know small businesses would provide the coverage if they could. What I'm trying to get at is—we had testimony in here about prior condition. People, because of a prior condition of a family member, cannot even get coverage. That's what we heard today.

If you had in your family a family member with a prior condition—a child with leukemia, for example—or you had employees who were dealing with that, you probably as a small business couldn't have a plan for anybody. Insurance companies wouldn't want to carry you. What are we going to do about that?

This bill, the HealthAmerica bill, takes care of that and makes sure that small business people can afford those premiums.

So I'm trying to get a sense for the basis of your opposition.

Mr. RISALVATO. If it were going to definitely guarantee that we would be able to afford it, it is a different story. Our side of the issue is we're saying it is not. If we don't address what is making the costs so high, then the costs will remain high. If the costs remain high, we are still not going to be able to afford it.

As far as things like pre-existing conditions, yes, that is a tragedy. Particularly last year, I received a notice from my insurance company—it was one of the opportunities when I wanted to switch because I was appalled at the rate increase that I was given—except I had an employee who had a back problem, had just developed it, and there was no doubt in my mind that he was going to need surgery. I could never, ever, ever switch insurance companies at that time. I would have been able to save almost $4,000 a year if I could have switched insurance companies at that time, but I also would have left an employee with probably well over $15,000 in medical expenses without coverage, because the new insurance company would not take him as a pre-existing condition.

Senator WELLSTONE. Well, you see, that's what you're about.

Mr. RISALVATO. What we have to do is we have to find a way to bring those costs down. When the cost of medical comes down, insurance rates should come down. When insurance rates come down, more small businesses will be able to provide that benefit. Now, remember, this is an incentive. This is a reason to provide something so that people will work for you. So certainly I would want to, and so would any other business. It is an incentive.

Senator WELLSTONE. But we don't want it to become—it is too important for it to become a bargaining chip. It cannot be that. Health care is not like that. It is sort of like businesses offer it, then other businesses don't, and then that becomes the way of attracting—but then the people who aren't fortunate enough to work for your kind of business go without anything.

Mr. RISALVATO. It's a bargaining chip when the employee comes to you and says, "I won't work unless I have it." It is an incentive when you have it and you can get somebody to work for you.

I'm saying that if small business could afford it, they would definitely, absolutely, positively want it because it is an incentive. It is not a bargaining chip.

Senator WELLSTONE. Let me make a point for the chairman and then ask a Paul Wellstone question, because I would have had some time, too. I think the chairman would have said—and I have a page of questions here, but we're running out of time—would have basically made the argument that I tried to make with you a moment ago, which is that we hear from small businesses everywhere about the premiums, that they just can't make it, and it is an intolerable situation. This bill is an effort to provide relief and support for small businesses. That's the way it is conceived.

Now, your concern is, hey, what are we going to do about the cost of this, though—that's what I'm wondering about—escalating medical costs—right?

Mr. RISALVATO. Yes.

Senator WELLSTONE. Let me just ask you a different question, which I asked of two former secretaries, and now I am speaking for myself and not the chairman. What about a system like the Canadian model, not totally like the Canadian model, where you don't have 1,500 insurance companies, and you've got a GAO study that comes out and says they don't have 1,500, they don't have all these forms, there is accountability built into the system, they make no bones about it, and they don't spend 25 percent of the health care bill on administrative and bureaucracy, and they saved $70 billion in the way they do it, and if we had their system we'd save $70 billion—some say more. What about that?

Mr. RISALVATO. My response to that is really very simply. I'm a businessman. I am really not familiar with all of the percentages and savings and figures. I can only tell you how a mandate to me that I either provide something or I pay a penalty—and that's basically what we're talking about here—if that mandate comes down to me, I can only tell you how that is going to affect me. And I can further say that for the past 10 years, I have provided these benefits.

We are in a very difficult economic situation right now. I have had a tremendous time making ends meet in my business—and we run a good business.

Now, one of the things that I should be allowed to think about is maybe if I save myself over $1,000 a month in medical premiums right now, might that make it more possible to either have another employee, to get more work in and have more productivity; will I be able to use that money just to pay the mortgage?

Now, if the government tells me beforehand, "No, you can't do that," that is an option that I have already eliminated, and that is in effect what this legislation does. You take away my options to run my business.

And again, my heart goes out to these people who were here. I'm a human being the same as you, and it affects me the same way it affects anybody else. But you can't have what you can't pay for.

And I am telling you that small business cannot pay for this right now, or they would be paying for it already.

What we've got to do is go after the people who have caused the problem, and that is the insurance, that is the legal industry, and that is the medical industry themselves. There is some profit-taking that goes on. In my report, there are examples. I could parade a roomful of small businesses that can give you stories that will make you cry also about how government regulation forced them out of business, or put undue hardship on them and their families, and they lost hundreds of thousands of dollars in money that was borrowed against their house to start a business to employ people in the community.

So those horror stories exist everywhere. And what it really boils down to is that we have to be responsible for ourselves. And certainly, while we've got a situation with examples like you've brought up here today that are tragic, they are responsible. Now, that may sound cruel; it is not meant to be. But everybody must be responsible for themselves. And I think if we bring the cost of health care down dramatically, then individuals would not be caught in a situation where an insurance policy ran out on them 5 days prior to when he was notified that his son had a deadly illness. I think he would have provided it himself. I think that other situations where people are without insurance, they provide it themselves in an interim period between employment in a situation where their employer does not provide it; they provide it themselves.

My dad, when I grew up, never, ever, ever would have allowed my family to be without health insurance. And I can tell you that I did not grow up in a wealthy family; we were middle class America, struggled to pay the bills, and I know my dad would have never had my family without health insurance.

It is the responsibility of the individual. And if it is more affordable, the individual will provide it for himself, and if it is more affordable, chances are small business will provide it for him.

Senator WELLSTONE. I think you should have the last word, because this could go on, and you have presented a different and an important perspective.

I can't resist for the record just saying that in the case of Mr. Homan, I want to point out that initially, as I understand his story, when he first found out about the illness of his son, he took a few days off from work and found himself without a job. And then——

Mr. RISALVATO. Well, that's a moral judgment.

Senator WELLSTONE [continuing]. Excuse me, I just want to be clear about what happened to him—and then what he found out was that if he were to then try to work, he couldn't get any health insurance through another employer or any kind of plan because of pre-existing condition. And then—because I know you are very, very strong on enterprise and self-initiative—here is a man who comes from a family who never received any welfare at all and found himself put in a situation where if there was going to be any coverage for his child, he would essentially have to go on Medicaid and therefore could not work, which to him is very important.

So I just want to point out that a lot of people—and I haven't even gotten to Greg and Joan's testimony—the only thing I would

take exception with is that people kind of made their own decisions and were responsible for these things.

I thank you very much.

Mr. RISALVATO. Thank you, Senator.

Senator WELLSTONE. The committee is adjourned.

[Whereupon, at 12:30 p.m., the committee was adjourned.]

HEALTHAMERICA LEGISLATION: IMPACT ON CHILDREN

WEDNESDAY, JUNE 12, 1991

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:12 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Adams, Wellstone, Jeffords, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. We'll come to order.

This is a very special day here in the U.S. Senate in our Labor and Human Resources Committee, to hear some of the youngest people in our Nation out about their interests and health challenges and to listen to their parents as well.

As we have said on many occasions like this, we are very, very much in debt to all of the families who are sharing their experiences with us. It is never easy for families to talk about their health challenges and illnesses. As a parent who has had that experience with two of my sons, I understand it very well.

This hearing is very important to awaken this institution, the Senate, to the extraordinary needs of children in our society and to give the Senate a real sense of what is happening among those who are facing the early years of their lives with these difficulties and the great difficulties that their parents are facing as well, worrying desperately about the well-being of their children and then the viciousness and the inhumane aspects of the financial problems that they face, in one of the most inhumane systems that exists, really, I think, in any industrialized society.

So I just in a general way want to thank all of you for being here.

I am pleased to open the second hearing on the HealthAmerica legislation introduced last week. This hearing focuses on the special needs and problems of children, who deserve a healthy start in life, but are increasingly denied it. Our goal in HealthAmerica is to guarantee affordable health care to every American family.

We share a sense of urgency because our health care crisis is constantly worsening, and every day that passes without action means more American tragedies.

The crisis we face has two central features. Too many Americans are uninsured, and health care costs are escalating too rapidly. Almost 100 million Americans either have no health insurance, or have insurance that even the Reagan administration said was inadequate. The number of uninsured is rising every day. No family can be confident that the coverage they have today will be there to protect them tomorrow. As costs continue to soar, health care is increasingly being priced out of the reach of the average family. The likelihood of financial devastation from illness is a cause of great concern, and so is the denial or delay of access to essential care.

According to surveys by the Robert Wood Johnson foundation, every year one million Americans seek health care but are turned away because they cannot pay, and another 14 million do not seek the care they need, because they cannot afford it. Two-thirds of the uninsured with serious health symptoms such as spontaneous bleeding or loss of consciousness do not see a doctor. A recent study in the District of Columbia found that almost half of the uninsured admitted to hospitals could have avoided hospitalization if timely care from a family doctor had been available.

We pay a heavy price—not only in dollars but in death, disability, and pain and suffering—for the failure to give our citizens the care they need.

More than one-quarter of the uninsured, 9.2 million Americans, are children, and for them the crisis can be devastating. More than one in every seven children is uninsured. Nearly one in every three poor children is uninsured. Three hundred thousand disabled children are uninsured.

Because of cutbacks by businesses on insurance coverage, almost 3 million dependents of insured workers lost coverage between 1979 and 1986.

Lack of insurance means lack of health care. One-quarter of America's children do not see a doctor even once a year. Too often, the only family doctor our children know is in the hospital emergency room. Thirty percent of American children do not get basic childhood vaccines, and in many communities it is an even higher percentage who don't receive them. In New York City, almost 50 percent don't receive basic immunizations, and primarily because of cost—the $85 to $100 that it costs the working family to provide immunizations for their children.

Measles, which was thought to have been largely eradicated years ago, reached 25,000 cases last year, and concerns are now being raised about the reemergence of other preventable diseases.

The neglect of children begins before they are born. Six hundred thousand uninsured women give birth every year. Two hundred thousand do not receive adequate prenatal care. American infants die at rates higher than any other industrial country—rates higher than Japan, Sweden, Finland, Switzerland, Canada, The Netherlands, France, Denmark, Germany, Norway, Spain, Australia, Great Britain, Belgium, Italy, Austria, New Zealand, Singapore and Hong Kong. We have the highest infant mortality in New Haven, CT. We have about the 8th-highest in the country in my own City of Boston; literally in the shadows of some of the greatest medical institutions in the world, we have some of the highest infant mortality.

Even if children are healthy, their parents may be sick and unable to get care, or their family's life savings can be washed away in a tide of medical bills. Covering children covers only half the problem. We also need to cover the parents as well, so that the whole family will truly benefit.

HealthAmerica will guarantee health care for all Americans, young and old, at an affordable price. Every working family will have basic coverage, either directly through the employer on the job, or through their employer's payroll contribution to the new AmeriCare program to be established by the bill, with premiums based on ability to pay.

The program will be phased in over a five-year period, in recognition of the current budget deficit, and in order to give small business time to adjust to the new requirements. But children will come first. The very first phase of the program will guarantee affordable health insurance to every child.

The basic benefit package also gives special attention to children. Consistent with current business practices, most preventive services are not covered, but coverage is required for prenatal care, well-baby care and well-child care.

The most important aspect of this program for children is not this particular benefit; it is the guarantee of basic health insurance protection for children and their families—all families—so that no lives will be blighted in the future by the financial or health consequences of uninsured illness.

In addition, HealthAmerica contains a tough new program to control health care costs. The program addresses all four parts of the cost issue—cost-shifting, unnecessary care, excessive administrative costs, and blank-check reimbursement for providers and hospitals. This program has been estimated to save $78 billion over the next 5 years.

Two children in my own family have had serious health problems. My son Teddy lost a leg to cancer at age 12. My son Patrick has severe asthma and also had a recent operation to remove a tumor on his spine that could have been disabling or even fatal if not diagnosed in time. My children had access to the best medical care, but too many American children do not. It is wrong that the quality of any child's health care should be determined by the size of the family's wealth or the fact that they are a Member of Congress or President of the United States.

The legislation we are considering today is good economic sense, and it is good health sense. Action is long overdue, and I intend to do all I can to see that we act in this Congress.

We'll begin today's hearing with a panel of three witnesses who will testify about problems they have encountered regarding health care coverage for their children.

Donna Johnson and her son Eric are from Sand Springs, OK; Pamela Boyer and her son Joshua come from Nelsonville, OH; and Pamela Punteney and her son J.R. have travelled here from Omaha, NE.

We'll ask if they'll all come up. We're looking forward to hearing your stories and learning from your experiences.

This sort of looks like a daycare center today. It is the largest number of children I've seen since I've been in Ethel's house. We

have 9 Kennedy children, 30 grandchildren, 28 great-grandchildren—and the oldest one is 10. So we are at least familiar with some of the squeals that we are hearing, and we welcome all of you here and hope that those who have rambunctious children will feel quite at home. All of us are used to hearing them.

We'll start with Donna Johnson.

STATEMENTS OF DONNA JOHNSON AND SON, ERIC, SAND SPRINGS, OK; PAMELA BOYER AND SON, JOSHUA, NELSONVILLE, OH, AND PAM PUNTENEY AND SON, J.R., OMAHA, NE

Ms. JOHNSON. Good morning, Senator Kennedy.

My name is Donna Johnson, and with me today is my son, Eric. We are both very pleased to be here to tell our family's story. We also need your help.

The last few years have been very difficult for us. Eric, his 8 year-old brother Chris, my husband and I no longer have health insurance. Our family lives day-to-day in fear that a major health emergency will financially destroy us.

I suppose you would describe us as a typical middle-class family living outside Tulsa, OK. A few years ago, I would never have thought we would have gone through the pain and frustration that we have lived through because services to assist children with disabilities are so inadequate.

The source of our greatest frustration has been our inability to secure affordable health insurance. Not having health insurance has greatly changed our lives. I hope our appearance here today helps to convince Congress that it has the responsibility to act, and to act soon, to guarantee access to health care for all Americans.

My son Eric celebrated his 4th birthday last week. An injury during birth left him with several disabling conditions, including epilepsy and cerebral palsy.

Our health insurance problems began when my husband, Alan, changed jobs 2 months after Eric was born. Alan is the office manager of a company which sells safety equipment. When Alan changed jobs, we were insured through Blue Cross/Blue Shield. His new employer also provided health insurance to its employees and dependents using Blue Cross/Blue Shield. While we anticipated that Blue Cross might impose a 6-month pre-existing condition clause on Eric, we never thought they would deny him coverage. After all, we were dealing with the same health insurer.

Because we were concerned over the possibility of a pre-existing condition clause, we thought it prudent to use the provisions of COBRA to maintain our existing coverage. Our worst fears occurred. Since my husband's new employer is a small business with only 15 employees, our family had to undergo medical underwriting.

The CHAIRMAN. Could I just interrupt you there? Do I understand it was the same Blue Cross/Blue Shield?

Ms. JOHNSON. Yes.

The CHAIRMAN. So it's just a change in your husband's job.

Ms. JOHNSON. A change in the company.

The CHAIRMAN. A change in the company. So you stayed with Blue Cross/Blue Shield but went with another company.

Ms. JOHNSON. That's right.

The CHAIRMAN. And they obviously were aware of the particular health needs.

Ms. JOHNSON. Yes.

The CHAIRMAN. It has always fascinated me that you can get a medical test in Miami and get denied for a pre-existing condition, and in the morning fly to San Francisco, and every insurance company up there will know about it. That's the marvels of communication.

I appreciate it. I just wanted to understand that more completely. Please continue, and take your time, too.

Ms. JOHNSON. Since my husband's new employer is a small business with only 15 employees, we had to undergo medical underwriting. We were informed that Blue Cross refused to cover Eric in any way due to his pre-existing condition.

My husband's employer tried to find another company to cover Eric, but couldn't. Eric isn't the only person excluded by Blue Cross/Blue Shield from its group coverage. Three other employees are also uninsured. I understand the legislation which you, Senator Kennedy, together with Senator Mitchell, introduced last week would prohibit insurance companies from discriminating against people with ongoing health conditions.

We remained insured until 2 years ago when our COBRA coverage expired on January 31, 1989. We had been paying just under $200 a month. When we explored converting our COBRA coverage to a family policy, we were told it would cost $475 a month. At the time, my husband was earning approximately $23,000 a year. We just could not afford to pay $5,700, or 25 percent of our pre-tax income, to Blue Cross/Blue Shield.

Our family has now been uninsured for 2 years. We have a mortgage to pay. While everyone except Eric could be insured through my husband's employer, we cannot afford to pay both the $200 monthly premium for family coverage and continue to pay the current costs associated with Eric's disabilities. Our family already has the distinction of having enough medical expenses each year to qualify to use the medical deduction line of the Federal income tax.

By necessity, Eric's needs come first. My husband, my other son and I must remain uninsured so that we can afford the antiepileptic drugs which Eric must take daily. Eric also requires to wear molded leg braces. Each pair costs $700. Since he is growing, he needs a new pair at least once a year. He needs a new pair now. We are not sure how we are going to pay for them.

I worked for 9 years as a legal secretary until Eric was born. After Eric's birth, I began working part-time since I needed to be available to take Eric to various therapy sessions and doctor appointments. As a part-time employee, I was not eligible for health insurance. I have worked out of my home for the last 2½ years. Last September, after 11 years with the same law firm, I was laid off due to the economy. Just this week, I was recalled by the law firm. Given Eric's age and needs, I still can't work more than part-time.

One of the most frustrating aspects of our family situation is the fact that we can't get help with Eric's medical expenses anywhere. We have been turned down by everyone. Eric has been rejected for

SSI and Medicaid. Why? Because we make too much money. These programs only allow a family of four to make between $1,400 and $1,700 a month.

We have applied for assistance from several nonprofit organizations, but these organizations get so many requests for assistance that they, too, have imposed strict eligibility criteria, and our family income is always slightly beyond the upper limit.

Our family needs help. We are not rich. We can't afford private therapy for Eric. The only therapy he gets is through the public school system. He is 4 years old and still cannot sit up.

Eric's wheelchair was given to us by another family whose child outgrew it. We don't know what we will do when he outgrows it. Dental care has become a luxury. Neither of our kids have been to the dentist for 3 years.

Eric was hospitalized for a respiratory infection in January. It had nothing to do with his epilepsy or cerebral palsy. This brief hospitalization cost us $2,700. We asked the Oklahoma Department of Human Services to waive it. Just last week we were told we didn't quality, again due to our income. We just paid off another hospital bill from 2 years ago. It never ends.

My family urgently needs help. We need health insurance. The existing system has failed my family. We are looking to you to change our country's existing system of health insurance since it failed us and so many other families in similar circumstances.

Our experience is not unique. Millions of Americans are denied health insurance just like Eric. Others simply cannot afford the health insurance when it is offered to them. We have too many other bills, including health care bills, to pay, so we gamble and hope that a major illness doesn't strike. This isn't a way to live, and it is not right.

Something must be done to force insurance companies to provide insurance rather than deny insurance. America doesn't tolerate discrimination in other aspects of life. Why do we allow insurance companies to discriminate against those most in need of insurance?

Our life is scarey. Living with so much uncertainty creates major stress. Please take action soon to help families like mine. Millions of Americans are looking to you and your colleagues to solve this problem now—not next year or the year after. All Americans must be given access to appropriate, affordable health care.

On behalf of the members of the Epilepsy Foundation of America and the United Cerebral Palsy Association, and the millions of children and adults with chronic health conditions who are uninsured, Eric and I wish to express our appreciation for this opportunity to tell our story. We hope it will make a difference.

Thank you.

The CHAIRMAN. Very fine. That is a very moving statement.

So we're talking about two members of a family who want to work, will work, have worked; the only limitation in terms of the part-time job of the mother is to take care of her children. Yet they are being told that there is really no hope for them unless they surrender, effectively, and depend upon the State welfare system. That is intolerable.

Let me ask you what kind of therapies did Eric have to give up when you became uninsured a couple years ago?

Ms. JOHNSON. Eric was in therapy until we ran out of insurance. He would go to physical therapy once a week and speech therapy once a week. At that time, they were $55 per session, so that was $110 per week or $440 a month. Obviously, we don't have that now.

He needs to see an orthopedic surgeon because his spine has started to curve. The initial appointment is $450. He has never been.

Things like eyeglasses. Our older son has eyeglasses and has to go every 6 months because his eyes change that often. So we get new lenses for him every 6 months. I have had the same pair for 3 years.

So it is those kinds of things where we have to continually cut back.

The CHAIRMAN. Does Eric require regular medication?

Ms. JOHNSON. Yes. He takes Depacote for his seizures. At one time he was also on Zoratin.

The CHAIRMAN. What about epilepsy-related tests and medications?

Ms. JOHNSON. I couldn't tell you an annual expense.

The CHAIRMAN. But you pay all those out-of-pocket.

Ms. JOHNSON. We pay them all out-of-pocket.

The CHAIRMAN. Has your husband considered changing his job and trying to get a position with a larger business in order to receive health benefits?

Ms. JOHNSON. My husband has a very good job for the company he works for. The only thing that is bad about this company is that they can't get him insurance.

The CHAIRMAN. The employer should be commended for at least attempting to fashion a program to try to relieve some of the aspects of the existing conditions which discourage small business employers from getting it.

Ms. JOHNSON. Yes, they tried.

The CHAIRMAN. I am just amazed that any of them get it or try to go about getting it. It is an extraordinary tribute to them, and what we are basically interested in is trying to ease that problem. But clearly, you have an example here of a very responsible corporate leader who has been attempting to do it not only for you, but I guess for the other families that would be affected, and the insurance companies are refusing to deal with that.

Ms. JOHNSON. That's right.

The CHAIRMAN. All right. I think it would be best to hear from all of the witnesses and then come back for the questions. We have been joined by Senator Wellstone and Senator Adams, and Senator Durenberger was here earlier. So if that is agreeable to my colleagues, we'll hear from all the witnesses and then come back for questions.

Pamela Boyer, please proceed.

Ms. BOYER. Good morning, Mr. Chairman, and members of the Labor and Human Resources Committee.

My name is Pamela Boyer, and I am here with my son, Joshua.

Seven years ago when Joshua was born, we had no idea what was ahead for us. He was a beautiful, healthy boy. We had the perfect family—a son and a daughter. At 13 months, Joshua was

unable to sit alone, crawl, or walk. This was when he was diagnosed as having cerebral palsy.

C.P. is a general term that encompasses a broad range of disabilities that are the result of damage to the brain during infancy or childhood. In Joshua's case, we do not know when the injury to his brain occurred—perhaps before he was born or during birth.

As you can see, we have been very fortunate, and Joshua is now walking with his crutches and is beginning to walk alone. He attends the same school his sister attends. However, it has taken a great deal of work on the part of many people, as well as Josh, to reach this point.

Josh began physical therapy as soon as the diagnosis of C.P. was made. He also has been receiving occupational therapy and speech therapy on a weekly basis. In the 6 years since we learned of his C.P., Josh has had nine surgeries that are directly related to his C.P., as well as having tubes in his ears three times.

He has had to have five pairs of braces because he outgrows them so fast. These have cost an average of $1,400 per pair. The doctors tell us that there will be more surgery in the future. He has almost outgrown the braces he now has and will need new ones soon.

Joshua's school system has been of great assistance in providing his therapies, even when their money is very tight. We are fortunate that the Lord has placed us in a town where the people are so very caring.

However, after surgery, Joshua needs additional therapy that the school cannot always provide because it is medical rehabilitation and not education related.

The company that insures workers at the William Brook's shoe factory where my husband works excludes Joshua from coverage. My husband, daughter and I are covered, but not Joshua.

During the summer, we qualify for public assistance coverage for Joshua, but during the school year, when I work as a deli operator part-time, our income of $1,200 monthly is too high to qualify for public assistance. Even with the two incomes, we cannot afford to pay out-of-pocket for Joshua's medical expenses. We could not finish paying for one pair of his braces before he needs a new pair. It would take a lifetime for us to pay for any one of his surgeries. Last year, I called 16 insurance companies and only found one that would even consider insuring Joshua. However, the monthly premiums of over $300 would be far more than we could ever hope to afford with our monthly income.

Even his basic needs of shoes—which he wears out because of his braces at the rate of one pair a month—puts a strain on our family budget.

We have tried many agencies and organizations to get help paying for Joshua's expenses. However, there are usually long waiting lists of children who need assistance, and these organizations only pay for certain expenses.

Our goal for Josh is for him to grow up and be an independent adult, with a job, home and family of his own. But by the time he gets there, our debt from medical expenses may be so great that we will never be able to pay them all.

Thank you.

The CHAIRMAN. Thank you very much.

Pam Punteney, we'll be glad to hear from you.

Ms. PUNTENEY. Good morning, Mr. Chairman and members of the committee.

I am here today with my son, J.R., to tell you about my family's recent experience with the health care system and how the gaps in both the military and commercial health insurance systems can leave families, and particularly their children, vulnerable to the costs of potential health care needs.

I and my family live in Omaha, NE. Last January, while my husband, Richard, was serving as an activated reservist in the Persian Gulf, my 13 year-old son was hit by a car while crossing the street. Prior to being called to active duty, my husband worked in Omaha as a labor worker in various positions. Most recently, he had been working as a plant foreman at a local manufacturing firm, a position which he had held since last summer.

While both my husband's employer and my own employer—a regional food chain called Hy-Vee—offered health insurance, we had elected family coverage through my job since it was less expensive than his firm's policy.

When my husband was called up for duty, I decided to reduce my hours down to part-time status in order to spend more time with my children during this difficult period. I have four other children in addition to J.R., ranging from 20 months up to the age of 13. At this time, we also decided to switch the children over to CHAMPUS coverage while I remained on my employer's health plan paying 90 percent of the monthly premiums, instead of the usual 10 percent for full-time workers.

On January 6, 3 months after my husband had left for the Persian Gulf, J.R. was struck while crossing the street less than two blocks from our home. He was rushed to the hospital where he immediately underwent 8½ hours of surgery to repair a laceration to his forehead. He also dislocated two vertebrae in his spine, suffered a concussion and now faces the need for reconstructive surgery to reopen his sinus passages.

By the next day, I found out that J.R. was going to be okay, thankfully, but I was told that due to the spine surgery and injuries, he would need further treatment and possibly additional surgery when his bones stop growing.

At that point I had two major concerns. First, I didn't know how to tell my husband about J.R.'s accident without burdening him with problems he didn't need to hear about. The last thing I wanted was for my husband to lose his focus while stationed in the Gulf and make himself more vulnerable during a war.

My second concern was how to pay for all of J.R.'s care. Fortunately, I was assured by my reserve unit commander that CHAMPUS would take care of 100 percent of J.R.'s bills instead of the usual 80 percent due to the extent of his injuries.

To date, I am still not sure how much of the bill CHAMPUS has paid. In the meantime, I have received three notices from the hospital that my balance is overdue. I have hired a lawyer to help sort out what, if any, portion of the bill I am responsible for. I am concerned about what my family's financial obligation is for J.R.'s care might turn out to be.

Ever since my husband arrived home in May, my concerns have changed. While I was thrilled to finally have him home safely, his return also meant our CHAMPUS coverage would end soon. When I tried to reinstate my health insurance through my employer, I was told that the plan would not pick up coverage for any of the care relating to J.R.'s accident due to a pre-existing condition exclusion. My husband's employer refused to insure J.R. as well. The irony is that if we had obtained coverage through my husband's employer, his employer would not be allowed to withhold coverage for a pre-existing condition due to a law passed during the war.

When I look ahead to the future—even the not-so-distant future—I am worried about how we are going to pay J.R.'s medical bills. Even though CHAMPUS coverage continues for the reservists for 30 days after they return home, for us, this coverage ends on June 17. Because J.R.'s blood count is still too low, we were forced to postpone the surgery to reconstruct his sinuses for several weeks, which will fall past when our CHAMPUS coverage expires.

In addition to that operation, we know that J.R. will probably require surgery on his spine several years from now when he stops growing. On top of all that, we aren't sure how much of the hospital and physician bills from the last few months are going to be picked up by CHAMPUS, and how much our family is going to have to pay.

In conclusion, Mr. Chairman, let me say this. When my husband was called up for active duty, he went with a clear conscience and without reservation having served in the Army for 9 years prior to becoming a reservist. Yet due to circumstances beyond our control, we have now fallen through the cracks of the military and commercial health insurance systems.

No family should be caught in the bind that we find ourselves in. We have learned the hard way that a person can't move freely from policy to policy in the current insurance climate. I would urge you to do something so that everyone, regardless of their situation in life, will never find themselves, because of no fault of their own, without basic health care protection.

Thank you.

The CHAIRMAN. Thank you very much.

Now, let me just get this straight. Before, your husband was a reservist, and you were covered and he was covered, but your family took coverage under your employer.

Ms. PUNTENEY. That's correct.

The CHAIRMAN. But he is also covered. Now he goes over to the Persian Gulf. You take care of your children, and J.R., who has an accident. Now your husband comes back, and his coverage doesn't include, as I understand it, coverage for the full family. Is that correct?

Ms. PUNTENEY. That's correct.

The CHAIRMAN. I offered an amendment to extend the coverage of CHAMPUS for a period of 60 days, and it was in sort of a committee room like this, and people would take their figures out and say, "Well, if we do that, it may cost $4 or $5 million more. Will you settle for 30 days?" Finally, it was 45 days in the conference, and we settled for 30 days, and people just signed off. Even if it had

been 45 days, your husband would have been able to get the coverage.

This is how my colleagues—and I obviously take responsibility as well—we go on to another issue, and there are other important issues. But here is a family who was involved in the Gulf War, and all these parades are going on, and here is a real, human life tragedy. When the parades have ended, you've got this family here who has got real problems. So people are down there, cheering—and Lord only knows the people who were there are brave and courageous, and each one of them deserves all the accolades they receive—but we should not forget others who were over there whose families have got real life problems.

Pam, I understand you were the support coordinator for the spouses of your husband's reserve unit, and I want to pay a tribute to you. I visited a number of the different units up in my State, and I found more good ideas, some of which we were able to move on, and others not so, but they played an enormously important role in helping all of us understand a lot of the tensions, particularly with regard to the reserve units and the Guard.

Do you feel that you and the spouses in your support group received adequate information about the transition from private coverage to CHAMPUS coverage and the switch back to private insurance?

Ms. PUNTENEY. No, sir.

The CHAIRMAN. That certainly is an important issue. I am on the Armed Services Committee, and we're always saying the backbone—and I believe it—are the personnel. And 17 percent of those who served in Vietnam were married; now, it is about 55 or 60 percent. If you are going to get the best and hold onto the best, you are going to have to be concerned about their families—and there is no reason not to be. And I know the members of this committee feel very strongly about it.

J.R., you appear to have survived the accident pretty well. It must have shaken you up a lot. How do you feel now?

Mr. PUNTENEY. I still have some pain in my back, and sometimes I have real bad headaches from my sinuses being clogged.

The CHAIRMAN. So you still have some discomfort. How do you feel about the future surgery? Would you like to get to it and get it over with and get back into the swing of things, or are you filled with some anxiety and concern about it?

Mr. PUNTENEY. I want to get it over with.

The CHAIRMAN. I think that's true of everyone who is faced with that kind of surgery, they'd like to get it past and get cooking.

Well, you have made a remarkable recovery, and I'm absolutely confident that you'll do exceedingly well.

Ms. Boyer, as I understand it, you really play roulette—Joshua, how are you?

Mr. BOYER. Fine.

The CHAIRMAN. Now, I see you have that Ninja turtle. Josh, would you tell us what you've got in your hand? Hold it right up there so all the Senators can see it. Now, what is that?

Mr. BOYER. A Ninja turtle.

The CHAIRMAN. Do you like those turtles?

Mr. BOYER. Yes.

The CHAIRMAN. Which one do you like the best?

Mr. BOYER. Leonardo.

The CHAIRMAN. What about Raphael? Is he pretty good?

Mr. BOYER. Yes.

The CHAIRMAN. And you have a sister named Casey; is that right?

Mr. BOYER. Yes.

The CHAIRMAN. Does she behave herself all the time?

Mr. BOYER. Yes.

The CHAIRMAN. Well, I don't find many brothers who say that about their sisters. [Laughter.]

The CHAIRMAN. I guess you wanted to see President Bush when you came to Washington, didn't you?

Mr. BOYER. Yes.

The CHAIRMAN. Well, I'm not sure we can arrange that, particularly those of us on this committee who are here right now. [Laughter.] We are very glad to have you here, and I'm going to ask your mommy a few questions. You can hang out there if you like.

Now, as I understand, Ms. Boyer, you are able to qualify for the support services, the braces and other support items which are necessary for Joshua, only in the summertime; is that right?

Ms. BOYER. Yes. I just found out Monday before we came that we are not going to qualify for it this summer.

The CHAIRMAN. So the only time you have had health coverage is during the summer months when, because you aren't working, your income level qualifies you for public assistance.

Do you expect that you will get covered this summer?

Ms. BOYER. I don't look for it, no. They say we are about $37 over the income limit.

The CHAIRMAN. So you are $37 over the eligibility rate because you are working. So without coverage for most of the year, does Joshua have any health care needs that you try to take care of during the summer months when he has been covered by public assistance?

Ms. BOYER. Yes. He's got braces due next month sometime, and we're going to have to go to one of the other agencies to try to get help with that.

The CHAIRMAN. Has Joshua ever been covered under a private insurance plan?

Ms. BOYER. No.

The CHAIRMAN. Have you ever found any plan willing to take him?

Ms. BOYER. No.

The CHAIRMAN. So you are really playing roulette with your income to try and time medical attention, his health care needs, let alone braces, to the summertime when you get some coverage; otherwise you are not able to do so.

I have a final question for the panel, and then I'll yield. How do you respond to those in Congress who say that we should not act decisively to reform the current health care system until we as a nation have adopted a consensus on the type of reform we should adopt; that we ought to study this problem some more?

What do you think, Ms. Johnson? Do you think we've studied it enough?

Ms. JOHNSON. I think the clock is ticking. Every day there are people without treatment, and it goes on and on. You can talk about things for years and never get anything done. Something has got to be done because people are missing out on care and benefits every day.

The CHAIRMAN. Ms. Boyer.

Ms. BOYER. I think it has gone on long enough. We need to get something done about it.

The CHAIRMAN. Ms. Punteney.

Ms. PUNTENEY. I don't think you have to sit on it any longer. There are people out there who have to have it. What are you going to do with us? You can't keep holding off. Like Ms. Johnson said, the clock is ticking, and the bomb is going off for us.

The CHAIRMAN. What do you say to those who say you can find particular witnesses like this in a big country, but it isn't really happening out there to real families? Is it really happening out there, every day, in every community?

Ms. JOHNSON. Yes, it is. And I didn't realize how many disabled children there were in the country until I had one. I never thought I would have one. And I think we all assume we are going to just have a long and healthy life with no problems, but life isn't that way. It's just not that way. What happened to us could happen to anyone in this room—anyone.

The CHAIRMAN. Thank you.

Senator Durenberger.

Senator DURENBERGER. No questions, Mr. Chairman.

The CHAIRMAN. Senator Wellstone.

Senator WELLSTONE. First of all, I'd like to thank each of you for being here, and I would echo the words of the chairman. He asked you about your own lives and what you've been dealing with and the extent to which you think that represents many other people around the country. And I think to the extent that your stories get told here in Washington, DC over and over and over again, so that the voice finally reaches here—that is when I think we will finally take the action we should take.

Two questions for everyone—and J.R., please feel free to answer as well if you so choose. What do you pin your hopes on for the future in terms of dealing with your medical bills? As you are here, what are you hoping to see happen here in Washington?

Ms. PUNTENEY. I would have to say I think something needs to be changed as far as changing from policy to policy; there should be some coverage until you pick up another one so that you are still covered, even past a grace period.

I think the information has got to be put out so you can understand it. There is so much that the insurance companies say in their words that is not interpreted for us to know before we make the move. I think that is a big problem.

To ask us where we go—we don't know, because we just take 1 day at a time. And when you've got a long road to go down, you don't know what is at the end of the tunnel.

Senator WELLSTONE. Well, actually, that answer was really helpful to me. What I'm asking—because unfortunately you are experts at the ways in which the medical system doesn't work—so what I'm essentially asking you is can you give me some advice, as you

think about your own experience, as to the very specific things that you think we need to change—and I'm not trying to point the finger of blame at anybody, but as you think about the steps we need to take. And Pam, you gave me some idea, which is that people need to have some sense of what it means when they shift from one insurance company to another where they are going to be at, what is going to be covered, what isn't going to be covered.

Could you just tick off for me some things, based on your experience, that you really believe ought to be incorporated into national health care reform, which is why we are here?

Ms. PUNTENEY. What I heard from mine, because we were military, had it been the soldier who had the coverage, then everything would be taken care of, if he were the primary. Where he was not, had we been told, I think the military and health care have got to cover the family, not just the soldier. I think that is one thing that really needs to be put in there is that the family, the spouses, need to be covered.

Senator WELLSTONE. And your husband while he was serving in the Gulf, he felt very confident that his family was covered——

Ms. PUNTENEY. We all did.

Senator WELLSTONE [continuing]. But you just didn't know.

Ms. PUNTENEY. I was the coordinator of the unit for the family support group.

Senator WELLSTONE. And you didn't know.

Ms. PUNTENEY. People came to me and asked me what do you do. I gave them the information based on what I believed. And there are other people who are in the same boat in my unit. So it is out there, all over.

Senator WELLSTONE. OK, thank you.

Pam.

Ms. BOYER. I think they need to do something about the medical coverage through the country and State departments. The financial guidelines they set are just too high. Like in my case, it just aggravates that $37 knocked Joshua out of getting coverage.

Senator WELLSTONE. For the Medicaid.

Ms. BOYER. Yes.

Senator WELLSTONE. It seems like—not that this would make you feel any better—but one of the things that is so important about what you have said is that in a way your family is so representative—I mean, people are either not old enough for Medicare, and even if they are, there is still the whole issue of catastrophic expenses and prescription drug costs, or people are not poor enough for Medicaid, and even if they are, Medicaid by no means covers all low-income people, or people just are not well-off enough, which is the huge section of the population right now, to purchase a really good health insurance plan. So you just fall between the cracks.

So one thing is ineligibility. What else would you want—if you could just give me your priorities, that would help me a lot as a Senator on this committee, especially since it is Senator Kennedy's committee and is clearly going to be taking the lead on health care.

What other priorities would you sort out for me?

Ms. BOYER. Well, the insurance companies that I have called all give the same excuse for not insuring Joshua; he is considered high risk—which I understand. We all know it is someone they are

going to have to pay money out to. But that is not to say that we aren't willing to pay the cost of the insurance. It's just the fact that they won't even consider giving it to him.

Senator WELLSTONE. How many times we've heard that. OK. So there is the whole government, the Medicaid part, just lack of coverage, and then you turn to the insurance company, and it is not there.

Are there any other things you would want to emphasize?

Ms. BOYER. Not that I can think of.

Senator WELLSTONE. Well, those are two really helpful policy points, and I appreciate it.

Donna.

Ms. JOHNSON. I would say number one, if I were given a wish list, I would say the whole pre-existing condition thing. My husband and I have been married 11 years. We have worked all those 11 years. We have always worked. We have always had insurance. But it is scarey to think that—in fact, one of the companies my husband worked for went out of business—then you are just out of luck unless you all happen to be completely normal and completely healthy. So the pre-existing condition excludes those who need it the most.

The other thing is when we have applied for public assistance, we are continuously denied any access to that system. All they look at is our income, and they will not take into account the medical bills that we are paying on.

I took a stack of bills this high when our son was in the hospital in January, showing we were paying at that time two other hospitals, we had neurology bills. His prescription drugs are $50 to $75 a month. They don't even consider that, and that is wrong. They need to look at the big picture. I think it is easy to look and say, "Oh, you make this amount of money, so you can afford to pay this"—but not when you are shelling out $300 or $400 per month on all these other bills. It can only go so far. Our money won't cover it all; it just won't cover it all.

So I think in the public assistance part of it they need to take into account all the other medical bills and not just income. I think there is a real problem there.

Senator WELLSTONE. The comments from all of you have been very helpful to me, and I'd really like to thank you for being here.

I said yesterday, and I don't want to feel like I'm becoming a broken record, but I didn't say it to you all, so I get a chance to say it to you. I just think that when people are willing to come in and talk about things in such a personal way, it has power far beyond anything I'll ever be able to say because you have had to go through it, and I really appreciate your being here before the committee. I think all of us feel very strongly about making a commitment to you that the words that you speak won't lead to anything. I think we are really committed to trying to really work hard to take what you have told us and try to fashion and develop a national health insurance program that will deal with these problems and will be good public policy for people.

Thank you very much.

The CHAIRMAN. Before recognizing Senator Adams, who is responsible for putting in so many of the preventive health care

measures in this legislation, I would say that it is an interesting fact that the fastest growing industry in America today is collection agencies. This is a wonderful statement about the growth of America. Prison guards is the second, and private guards are the third. It is a real indication of something.

Senator Adams.

Senator ADAMS. Thank you, Mr. Chairman.

I want to thank you for holding these hearings, and I am in complete support of reforming our health care system. I hope it will be HealthAmerica or something similar.

I am very sorry, Pam, that your situation existed the way it has. We formed a committee under Senator Mitchell's direction to deal with the families of service members—Senator Kennedy and I were both on it, as he mentioned previously. We wanted to be very certain that families were protected as were their homes, insurance, and other needs that might have been disrupted because of the Gulf War. You should not have lost your benefits—I hope you are in contact with your congressional representatives and that they try to help you with that, because it was not intended that people be dropped or that they be injured because of the Gulf war.

I will not go into any detail at all because I think Senator Wellstone has done that very well. But one of the great problems that this committee faces is access by the working families of America to a basic health care program that all can have, and you have stated it very well.

Mr. Chairman, I want to put my statement in the record. I will not give it in full, but there is just one part of it that I want to emphasize, and that is that because health care issues have become such a major issue, and as has been pointed out by Ms. Johnson, are constantly escalating, I just think we have to now say, and I hope we will as part of this bill, that we do not have doctors and those who are doing the prescriptions profiting from self-referral to laboratories that they own or medical facilities in which they have an immediate family ownership. I know this is controversial, but I think that we have to separate the two of those, and I set it forth in greater detail, Mr. Chairman, in my statement so the committee can look at it. I tried to put it in in the Clinical Laboratory Act, because all the members you see sitting before you have been working on health matters for many years, and your testimony is extraordinarily helpful to us in dealing with these kinds of problems. We are trying to cover all of them.

I thank you, Mr. Chairman, and I ask that my statement be included in full in the record.

The CHAIRMAN. It will be included in its entirety in the record.

[The prepared statement of Senator Adams follows:]

PREPARED STATEMENT OF SENATOR ADAMS

Mr. Chairman, I want to thank you for holding this hearing on health care reform and cost containment. The escalating cost of health care is a number one issue in my state. Health care costs consume a greater and greater share of our country's gross national product every year. But Americans aren't necessarily getting better care for all this money. In fact, too often they are getting

unnecessary services. The growing practice in this country where doctors send their patients out for tests conducted at laboratory and medical facilities where they have a financial interest is contributing to the enormous increase in the cost of our health care. This practice must be stopped.

I will be introducing a health cost containment bill shortly that will prohibit physicians from self-referral to a laboratory or medical facility in which the physician or an immediate family member has an ownership or other financial interest. The bill will also prohibit physicians from billing for tests that they have neither performed nor supervised. Mr. Chairman, I included a similar proposal that this Committee considered but was unable to finally include as part of the Clinical Laboratory Improvement Act in 1988.

But I am back, even more determined to see this legislation become part of our health care reform package. The studies on the ethical abuses arising out of current referral and billing practices done by the Office of the Inspector General, the General Accounting Office (GAO), The New England Journal of Medicine and others are shocking. The situation has gotten much worse since this Committee first considered this proposal.

In 1989, the Inspector General found that patients of physicians who owned or invested in clincial laboratories received 45 percent more lab tests than all Medicare patients and 34 percent more services from independent clinical laboratories than all Medicare patients. The cost to the government for excessive laboratory testing equalled almost $30 million dollars in 1987. Many suggest that the unnecessary cost of medical services may be as high as $200 million today.

The bottom line is that when physicians own laboratories or have a financial interest in medical testing, they order more laboratory services than non-owners and charge considerably more for these tests. The GAO found that for imaging services, patients paid almost twice that per visit when their doctor had a financial interest in the medical facility.

Even when doctors refer patients out for services they frequently add on additional costs for the test. This mark-up of laboratory testing further contributes to unnecessary costs for patients.

My bill will put an end to this type of unethical and costly medical practice. Patients need to be able to trust that when their doctor orders a laboratory test or an x-ray it is medically justified. Under the current system, they cannot.

Mr. Chairman, I look forward to working with you on this bill and seeing it move quickly. Thank you.

The CHAIRMAN. Thank you all very much. As I have said on other occasions, I think the best way we can thank you is to recommit ourselves to providing a national health insurance program that is worthy of its name. All of us are committed to that, and we will fight for that.

Our second panel consists of two distinguished physicians representing organizations that have children's welfare as their paramount concern. Reed Tuckson is senior vice president for programs at the March of Dimes and former commissioner of health of the District of Columbia, and Antoinette Eaton is president of the American Academy of Pediatrics.

I might say, Dr. Eaton, I looked back over the Academy of Pediatrics recommendations 16 years ago compared to what they are today, and they are virtually identical. I'm going to make a point of looking back, because we hear on the floor that we need more study, more review, more examination—and Lord only knows what you're recommending today, you recommended 16 years ago and would be recommending 16 years from now if we don't pass it. But that is something else.

Dr. EATON. And we hope to get it accomplished.

The CHAIRMAN. Dr. Tuckson, we're glad to have you here.

STATEMENTS OF DR. REED TUCKSON, SENIOR VICE PRESIDENT FOR PROGRAMS, MARCH OF DIMES BIRTH DEFECTS FOUNDATION, MAMARONECK, NY, AND DR. ANTOINETTE PARISI EATON, PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS, COLUMBUS, OH

Dr. TUCKSON. Thank you very much, Senator Kennedy.

My name is Dr. Reed Tuckson, from the March of Dimes. I really want to thank you as well as the Senate leadership for providing not only this hearing, but your work on the bill.

While I am concerned about health care for all Americans, I am especially pleased at this bill's attention to the needs of women and children. I will submit my comments for the record, but I want to speak to you this morning, sir, and members of the committee, from my heart and from my experience.

I understand well the urgency and tragedy of infant survival in America. As the former commissioner of public health in this city, someone who has been responsible for making health care policy at the local level and directly providing care for our pregnant women in the poorest sections of this city, and now in my role at the March of Dimes, traveling across this country every day, seeing the problems first-hand, I am well aware of the relationship between lack of access to health care because of financial barriers and infant death and disability.

When I was thinking of what I would say today in my room last night, I could not help but be aware that across America last night, 100 women were crying themselves to sleep because they lost their babies last night, who died in their first year of life. I could not help but be aware that tonight and tomorrow night and a month from today, 100 women will lose their babies in the first year of life. That's what an infant mortality rate of 40,000 babies a year means.

I could not help but be aware that 250 women were crying themselves to sleep because of their fear for their babies, born last night, born today, with serious birth defects.

What I knew from my experience, the Institute of Medicine has studied from an academic perspective, and they said clearly, financial barriers, particularly inadequate or no insurance and limited personal funds, are the most important obstacle to insufficient care. This is the reality. But despite our work on this for years and years and years, as you well know, sir, and despite our excuses, a decade ago, one-fourth of all our pregnant women did not receive care in the first trimester of life. Today, despite all of our conversa-

tion and talk, one-fourth, 25 percent, still do not receive care in the first trimester of life.

You know, Senator Kennedy and members of the committee, and should be aware that 10,000 babies could be saved each year if we just use the knowledge and information we have now and provide first trimester care, care through the infant's first year of life—10,000 babies each year in this country. What possible excuses could justify the death and disability of so many children? Now we don't provide that care, and when people don't have insurance, where do they go? Well, either they don't seek care at all, or they come to the public sector.

Senator Kennedy, I remember well a visit that you made with me——

The CHAIRMAN. Yes, and I do apologize for not bringing that up at the introduction. I remember very well our visit to the DC Hospital and visiting the clinics, and I remember your very impressive comments at that time. I do apologize.

Dr. TUCKSON. And you know, and you saw the lack of resources available at the public sector, the clinic system in this city, in New York, St. Louis, Chicago—anywhere you go, health departments are being dismantled, so the resources are simply not there.

We need to act, and we need to act now. Leadership is needed. No more excuses. Let's provide coverage that, first, is comprehensive and provides preventive as well as therapeutic services, that provides genetic testing and counseling for the prevention of birth defects, the leading cause of infant death. Let's make sure we provide coverage with special emphasis on drug treatment for women who are suffering from the disease of addiction and who are pregnant.

Second, let's provide coverage for services for physicians, nurse midwives, nurses, and other allied health professionals in a cost-effective and appropriate manner.

Third, let us make sure that such coverage is not dependent on employment status. Six million women, sir, are without insurance, but another 5 million women are employed, with insurance, but have no maternity coverage.

Fourth, let's make sure that our coverage does not demand deductibles and coinsurance——

The CHAIRMAN. Let me get that straight. What was that figure again, 6 million——

Dr. TUCKSON. There are 6 million without insurance at all; and then another 5 million who are insured, but have no maternity coverage.

The CHAIRMAN. I see; they are working and are covered with some form of insurance, but don't have maternity. Thank you.

Dr. TUCKSON. Let's make sure that we don't demand deductibles and coinsurance. I saw first-hand in this city that when we demanded payments and deductibles and coinsurance for poor people that they simply did not come out and make use of care. When we eliminated that barrier, our clinic visits for prenatal care increased by 22 percent in 1 year. So I know what that means; I have seen it first-hand.

Finally, Senator, let us of course take great care to include——

The CHAIRMAN. What was the deductible at that time?

Dr. TUCKSON. Senator, we were charging on a sliding fee scale, dependent on the amount of income—and it was a very liberal sliding fee scale.

The CHAIRMAN. Yes, very low.

Dr. TUCKSON. But it still acted as a barrier to access.

The CHAIRMAN. I'm glad you mention that. Our program has the deductibles and copays, but you don't have to convince me that it keeps people away. The fact of the matter is that overutilization of services is not by working folks; in many cases it is by people who haven't anything else to do. People don't go down there and give up a day's pay and wait to get care for themselves and their children because they want to abuse the health care system—but I don't think you and I have to argue that one at all.

Dr. TUCKSON. No, sir.

And finally I would just say in conclusion that of course—and one of the things that I was encouraged to read in the bill—we absolutely must enact cost controls. That is an absolutely prerequisite for us to be successful.

Mr. Chairman and members of the committee, again, it is extraordinarily important that this debate now take on the level of urgency that gets us to, as a Nation, appreciate and do something about the reality that tomorrow and the day after that, another 100 women are going to be crying themselves to sleep because they lost their babies in the first year of life. Thank you.

The CHAIRMAN. Thank you very much, and I would just make a correction that for the very poor, there are no deductibles or copays in our bill, but there are some for working families.

[The prepared statement of Dr. Tuckson (with attachments) follows:]

PREPARED STATEMENT OF DR. TUCKSON

Chairman Kennedy and Members of the Committee, on behalf of the March of Dimes Birth Defects Foundation, I would like to thank you for the opportunity to appear before you today. Mr. Chairman, I also would like to commend you for your long-term commitment to reforming the nation's health care system. The March of Dimes shares the concern of other voluntary health organizations, health professionals, business, labor, and elected officials about the growing number of uninsured Americans, the high (and growing) cost of health care, and the barriers to access to care these problems create for millions of American families who want to have healthy babies.

In the interest of time, I will keep my remarks very brief. My written testimony includes not only a fuller version of my statement, but a copy of testimony prepared by the March of Dimes in 1975 on the subject of national health insurance. I resubmit this older testimony because of the striking relevance of its key points to today's topic.

It is a disgrace that the problems of maternal and infant health have in many ways worsened since 1975 and that our recommendations for expanding access to care must be essentially the same as those we made 15 years ago. Despite all of the rhetoric about improving infant survival, our policies and statistics do not reflect a full commitment health care. The situation becomes increasingly outrageous and dangerous as each year passes without major reforms being enacted. When it comes to infant survival, we do not have the luxury of time to exchange rhetoric in a lengthy debate. The nation's losses in productivity, fiscal resources, and human capital are mounting. America simply cannot afford to continue on its present course.

Building on our 1975 testimony, I would like to briefly review seven summary points.

1. *In 1989 the United States ranked 19th among nations in infant survival.*

—Our international ranking has fallen since 1975 and our infant mortality rate places us in a tie for last place among our industrialized peers.
—Last night, in this country, 100 women cried themselves to sleep because of the loss of their babies who died in the first year of life.
—Each year, the nation loses nearly 40,000 infants to premature death. Yet we know that one-quarter of these deaths could be prevented with the knowledge and technology now available.

Infant mortality rates are one of the most sensitive indicators of the overall health and well-being of our citizens. Our poor performance in infant survival is a terrible symptom of the inadequacies of our health care system.

2. *Univeral provision of high quality medical care beginning in the first trimester of pregnancy and continuing for the infant after birth could reduce the risk of infant mortality and morbidity by one-quarter.*

While many factors contribute to the nation's disgraceful standing in infant mortality, inadequate access to care during pregnancy is a major contributor.

—We have made no progress in improving early prenatal care use since 1979. One-quarter of all pregnant women receive no prenatal care in the critical first three months of pregnancy.
—Each year, approximately 70,000 babies of all colors are born without benefit of any prenatal visits—this means that their mothers did not see a health provider before they arrived at the hospital to give birth.
—Birth defects, low birthweight and prematurity are among the leading causes of infant death. Over 100,000 of the 400,000 disabling conditions that result from these conditions of birth could be prevented through enhanced access to comprehensive maternal and infant health services.

3. *Governmental action affecting maternal and infant health programs should act as an inducement to utilization of early, preventive care.*

Addressing financial barriers to care must be the first step in health care reform. Time and time again, studies have shown that financial barriers are the greatest hurdles families must overcome in seeking maternity care. In a landmark report on prenatal care, the Institute of Medicine reported that:

> "Financial barriers—particularly inadequate or no insurance and limited personal funds—were the most important obstacles reported in 15 studies of women who received insufficient care."

Policymakers also will have to address problems related to the distribution and supply of health care providers. Currently 30 million Americans live in medically underserved areas and lack a source of basic, primary care. Even where publicly-funded clinics exist, they generally are overburdened, understaffed, and underfunded.

4. *The nation's health care financing system should ensure comprehensive coverage of health services related to care of mother and fetus during pregnancy and care of newborn during delivery and during infancy. Any "minimum" benefit package should include appropriate preventive and treatment services.*

—The majority of the uninsured live in young, two-parent, low-income, working families with children. The typical woman having a baby is from such a family—in her 20's, married, family income of just under $20,000 per year, with at least a high school education, and employed or married to a man who is employed, full-time.
—The average bill for having a baby is estimated at over $4,000. This a conservative estimate—assuming that there are no complications—represents one-fifth of the average income of a couple in their early 20's. The ability of single mothers to shoulder maternity care costs is even more limited.
—Uninsured pregnant women often cannot afford to purchase the basic services that would have given a baby a chance to survive, such as genetic screening, counseling, and treatment. Screening newborns for birth defects and vaccinations are other examples of the type of cost-effective services that should be covered.
—Comprehensive prenatal care also includes special services such as smoking cessation programs and drug and alcohol treatment for high risk women. Again, these services have been proven to be cost-effective and should be covered.

5. *Services of physicians, nurse midwives, nurses and other appropriate health personnel in and out of hospital should be covered.*

Providing a comprehensive array of maternal and infant health services requires the services of a variety of providers. For example, genetic and nutritional counselors provide important prenatal services.

Ensuring access to the most appropriate and cost-effective care requires coverage of a range of providers. In some cases, the highly technological services of neonatal intensive care are the key to infant survival—leveling the playing field for infants who face high-risks from prenatal insults such as drug exposure. In other cases, the "low tech" services of nurse midwives are most appropriate for medically low-risk pregnant women.

6. *Such insurance should be universally available and should not be dependent on employment status.*

The numbers of uninsured Americans under age 65 has grown in recent years. Since the greatest erosion has been in dependent coverage, women of childbearing age and children are disproportionately represented among the uninsured.

—The U.S. stands alone with South Africa among industrial nations in its failure to provide universal coverage of maternal and infant health.

—Despite recent expansions of Medicaid, in 1989 over 6 million women of childbearing age had no health insurance, public or private. An additional 5 million women who have some private, employer-based coverage but none for maternity care.

7. *Such insurance should have no economic deterrents such as deductible or co-insurance provisions.*

When families delay preventive care, society pays. We pay when a woman faces financial barriers to prenatal care that result in $10,000 per day in neonatal intensive care costs for a low birthweight baby. We pay when infants do not receive vaccines and a case of preventable pertussis or measles is the result. We know that we could be saving $3 for every $1 we invest in comprehensive prenatal care and $10 for every $1 we invest in immunizations. Given these facts, we should have reached consensus on providing universal access, without financial barriers, to these life-saving and cost-effective services.

Conclusion

It is clear that something must be done. We recognize that the policy debate on health care reform is gaining momentum and that this debate will more clearly show the strengths and weaknesses of various approaches.

The March of Dimes strongly supports an approach that gives priority to pregnant women and children. This means ensuring that all pregnant women and children have health care coverage and that the benefits provided under a new system be adequate to meet the needs of these populations.

We believe strongly that the unique needs of pregnant women and infants must be considered in the health care reform debate. To that end, we are supporting and helping to finance a project of the National Academy of Sciences, National Forum on the Future of Children and Families that will develop criteria for evaluating the adequacy of health care reform proposals in relation to maternal and child health needs. The National Academy of Sciences working group, and other similar groups, begin with certain guiding principles. These include that: (1) All pregnant women and children are entitled to a basic level of high quality preventive and treatment services; (2) Many of the preventive and special services important to maternal and child health do not fit easily into the traditional insurance model; and (3) Health care coverage should not be dependent on income, race, geographic location, marital status, or other artificial criteria that have limited access to care.

The March of Dimes applauds the efforts of this Committee and other Congressional leaders aimed at enactment of health care reforms this year and pledges the assistance of our resources, including millions of March of Dimes volunteers, in finding workable solutions for the enormous problems we face in improving the health of America's mothers and babies. We are especially pleased that the Americare proposal: (1) gives priority to pregnant women and children; (2) aims at universal coverage for all Americans; (3) protects those living in poverty from additional costs; and (4) includes a plan for financing, with special considerations given to small businesses.

Ways and Means Committee
April 15, 1975
Hearing on National Health Insurance
Testimony of Joseph Nee
President, March of Dimes

Summary

a. In 1975 the United States ranked 18th among nations in infant survival.

b. Universal provision of high quality medical care beginning in the first trimester of pregnancy and continuing for the infant after birth could reduce the risk of infant mortality and morbidity by one-third.

c. Governmental action affecting maternal and infant health programs should act as an inducement to early utilization.

d. National health insurance should include full coverage of all health services related to care of mother and fetus during pregnancy and care of newborn during delivery and during infancy.

e. Services of physicians, nurse midwives, nurses and other appropriate health personnel in and out of hospital should be covered.

f. Such insurance should have universal coverage and not be work-related.

g. Such insurance should have no economic deterrents such as deductible or co-insurance provisions.

Labor and Human Resources
Committee
June 12, 1991
Hearing on Health Care Reform
Testimony of Dr. Reed Tuckson
Senior Vice President for Programs
March of Dimes
Birth Defects Foundation

Summary

a. In 1989 the United States ranked 19th among nations in infant survival.

b. Universal provision of high quality medical care beginning in the first trimester of pregnancy and continuing for the infant after birth could reduce the risk of infant mortality and morbidity by one-quarter.

c. Governmental action affecting maternal and infant health programs should act as an inducement to utilization of early, preventive care.

d. The nation's health care financing system should ensure full coverage of all health services related to care of pregnant women and infants. Any minimum benefit package should include appropriate preventive and treatment services.

e. Services of physicians, nurse midwives, nurses and other appropriate health personnel in and out of hospital should be covered.

f. Such insurance should be universally available and should not be dependent on employment status.

g. Such insurance should have no economic deterrents such as deductible or co-insurance provisions.

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WRITTEN STATEMENTS

SUBMITTED BY

INTERESTED INDIVIDUALS AND ORGANIZATIONS

ON

NATIONAL HEALTH INSURANCE

APRIL 15, 1975

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STATEMENT OF JOSEPH F. NEE, NATIONAL FOUNDATION PRESIDENT MARCH OF DIMES

SUMMARY

1. *Name, capacity and address.*—Mr. Joseph Nee, President, The National Foundation-March of Dimes, 1275 Mamaroneck Avenue, White Plains, New York 10605.

2. *Organization represented.*—The National Foundation-March of Dimes, 1275 Mamaroneck Avenue, White Plains, New York 10605

The National Foundation has approximately 2,300 local Chapters in each area of the United States.

Total volunteer membership is several hundred thousands.

3. *Summary of comments and recommendations.*—

(a) The United States ranks 18th among nations in infant survival

(b) Universal provision of high quality medical care beginning in the first trimester of pregnancy and in the neonatal period could reduce the risk of infant mortality and morbidity by one-third.

(c) Governmental action affecting maternal and newborn programs should act as an inducement to early utilization.

(d) National health insurance should include full coverage of all health services related to care of mother and fetus during pregnancy and care of newborn during delivery and during infancy.

(e) Services of physicians, nurses and appropriate health personnel in and out of hospital should be covered.

(f) Such insurance should have universal coverage and not be work-related.

(g) Such insurance should have no economic deterrents such as deductible or co-insurance provisions.

STATEMENT

The National Foundation-March of Dimes is the voluntary health agency which organized and directed the conquest of poliomyelitis and is now dedicated to the prevention and amelioration of birth defects and related conditions of prenatal origin which affect the outcome of pregnancy. It pursues its objectives through the support of basic and clinical research; the education of health professionals and the general public; and the sponsorship of regional and community health service programs. The Foundation has some 2,300 local Chapters with a constituency of scores of thousands of volunteers.

Recent activities of the Foundation have been focused on improving the quality, availability and utilization of health services for the pregnant woman and her newborn infant. Our Chapters make grants to medical schools, hospitals and health departments for the delivery of specialized medical and nursing services to high risk maternity patients and to their critically ill newborn. The Foundation sponsors cooperative efforts by organizations of health professionals to develop guidelines for the regionalized perinatal health services to improve the quality of these services at all levels.

Many of our local Chapters have helped to establish prenatal care clinics and nurse-midwifery programs in inner-city and rural communities. Through "Operation Stork", "Better Infant Births" and similar projects, cosponsored with the Junior Women's Clubs, B'nai B'rith Women, The National Council of Catholic Women, the Jaycettes and other organizations, the Foundation has initiated programs to motivate women to obtain prenatal care at the earliest period during pregnancy. To increase the effectiveness of these prenatal care programs, educational materials and volunteer services are being provided.

Our participation in these programs, as well as the experience of the Maternal and Infant Care projects of the Department of Health, Education and Welfare indicate that the universal provision of high quality medical care beginning in the first trimester of pregnancy and in the neonatal period could significantly reduce the risk of infant mortality and morbidity. Unfortunately, however, the current health care system does relatively little to encourage early prenatal care as is reflected by the continued deterioration in the position of the United States, relative to other countries, in the survival of the newborn. In 1950, this country ranked fifth among nations in infant survival; in 1972 it ranked 15th; and in 1973 it dropped to 18th.[1]

The recent report of Chase and associates,[2] based on a study of a cohort of 142,000 births in New York City, showed that the pregnancies at greatest risk received the least amount and poorest quality of medical care. This would indicate that if these high risk patients received the kind of care given to those with the best outcomes, infant mortality in the city would have been reduced by one-third. Projected on a national basis, improved delivery of care could save some 22,000 babies each year.

This and related experience emphasizes the importance to maternal and newborn health of the availability and utilization of high quality perinatal care beginning early in pregnancy. In its consideration of legislative proposals for national health insurance, therefore, we believe that the Committee has a unique opportunity to encourage the provision and utilization of such care on the widest possible scale. It is of extreme importance to the outcome of pregnancy that maternal and newborn health programs, whether private or governmental, act as an inducement and not as a deterrent to their early utilization.

We therefore urge the Committee to include in any national health insurance bill which it adopts full coverage of all health services related to the care of the mother and fetus during pregnancy and the care of the newborn during delivery and thereafter in infancy. The services of physicians, nurses and all appropriate health personnel, both in and out of the hospital, should be covered.

[1] Statistical Office of the United Nations; data corrected to April 1, 1975.
[2] Chase, H. et al., A Study of Risks, Medical Care and Infant Mortality. American Journal of Public Health, Vol. 63, September 1973 (Supplement).

To bring all pregnant women and newborn into the health care system, we also urge that such insurance should have universal coverage and it should not be work-related. The experience in 1975 when at least 5,000,000 families have lost their health insurance coverage due to unemployment demonstrates dramatically that such work-related insurance coverage has deprived, and will in the future, deprive families of needed coverage when they may well most require it.

Further, as a voluntary health agency close to the health problems of predominantly young families, we urge that any national health insurance program covering preventive, early diagnostic and treatment services should have no economic deterrents, such as deductible and co-insurance provisions.

Only with the foregoing provisions can there be any assurance that national health insurance will provide quality health care to pregnant women and the newborn.

We wish to thank the Committee for this opportunity to present our views which are shared by our many volunteers throughout the nation.

The CHAIRMAN. Dr. Eaton.

Dr. EATON. Mr. Chairman and members of the committee, I am Antoinette Parisi Eaton, president of the American Academy of Pediatrics and here today representing the 41,000-plus pediatrician members of the Academy who are dedicated to the health and well-being of infants, children, adolescents and young adults in this country.

I very much appreciate this opportunity to address the important issue of children's access to health care.

Let me begin by taking this opportunity to commend you, Mr. Chairman, along with Senators Mitchell, Riegle and Rockefeller, for your recently introduced legislation and today's hearing, which clearly demonstrates your commitment to the critical issue of access to health care.

Through your actions, the debate on health care reform has finally begun. Now we must move that debate forward.

For far too long, children's lack of access to health care has been largely ignored by our society. As this committee knows, we cannot afford to ignore this crisis any longer.

The time has come for our country to make the health and well-being of its children the highest priority. Former Surgeon General C. Everett Koop recently stated that, "We have the capacity to provide the best health care in the world for our children, but first we must remove the barriers in the system that deny that care to many and place our children at risk."

Last week a major step was taken in that direction. With the introduction of S. 1227, the "HealthAmerica: Affordable Health Care for all Americans Act", a strong signal of hope to millions of Americans, many of whom we have heard from today, in need of appropriate health care, was delivered. Through your leadership, national health care reform has finally become the focus of national attention.

Over the past 2 years, the Academy of Pediatrics has developed a plan to provide access to health care for all children and all pregnant women. The Academy plan builds on the current free enterprise system of health insurance and the shared financial responsibilities of the public and private sectors. It will provide preventive, acute, chronic and rehabilitative services to all children and pregnant women.

Using the Academy plan as a benchmark to evaluate all other health care access plans, the American Academy of Pediatrics intends to speak out at every opportunity to ensure that children and pregnant women are first, not last, on the priority list to receive the health care they so desperately need.

Based on that benchmark, we are pleased that the "HealthAmerica Act" embraces many of our concepts and incorporates them in this debate. These include beginning with children and pregnant women first; requiring basic benefits; eliminating financial barriers to health care; refocusing Medicaid dollars in a more efficient and effective program; providing preventive services including prenatal, well-child and adolescent care; utilization of guidelines for quality assurance; and requiring insurance reforms. These are concepts that we strongly support.

Although we believe the preventive care could be enhanced, for example, to include preventive dental care, we are encouraged to note that the legislation does consider preventive health care an integral part of its basic health plan. The HealthAmerica Act includes a new Federal-State program of public coverage called AmeriCare. Benefits under AmeriCare will be the same as those for employment coverage, except that early and periodic screening, diagnosis and treatment, the so-called EPSDT portion, will be available under the public program.

While the Academy of Pediatrics applauds the inclusion of vital EPSDT services in AmeriCare, we would urge that these very essential services also be included for employment coverage to ensure adequate coverage for all children in need.

The many services provided through EPSDT such as assessment of health, developmental and nutritional status, along with appropriate immunization and vision, hearing and dental screening, are important to effective preventive care for children and youth at all income levels.

In many ways, our society strives to protect our children from the many hazards that surround them—from the use of infant carseats to bicycle helmets, we don't hesitate to ensure our children's safety and well-being. Yet tragically, we have left millions of our Nation's children unprotected from disease due to access to appropriate health care. For those children and their families, each day represents another threat of illness and financial ruin, and nothing that I could add at this point could say it more eloquently than the families that appeared in the first panel today.

The fact is, a disproportionate number of those without health insurance are children and pregnant women, our most vulnerable population. Approximately 12 million children a year have no health insurance. Millions more are underinsured. They are without adequate insurance coverage for necessary medical services for even the most basic preventive care. Still others are uninsurable because of preexisting chronic or recurring conditions, again exemplified by the individuals on the first panel.

Families with special needs children should not be further burdened with significant concerns about how to finance the critical and often multiple health services needed. They simply should not have to worry about finances.

Surprisingly, a large number of uninsured children do not come from stereotypical "poor families". More than half of all uninsured children live in families with incomes above the poverty line. Less than one-fourth are minorities, and more than half live in two-parent families. Beyond the numbers, however, as we have seen this morning is the unnecessary suffering. Not only are uninsured children unable to receive medical attention when they are sick, but they also fail to receive preventive care.

The Academy believes that preventive care is critical to any proposal designed to provide a healthier future for our children. What children need most is preventive care and early treatment of acute and chronic illness, especially on an outpatient basis. Often these services can eliminate the need for more costly procedures and hospitalization.

Lack of preventive care can lead to dire consequences. Studies show that uninsured children are more likely to be reported in poor health than are children with insurance. Uninsured children are less likely to be immunized, as you noted in your introductory comments, than children with insurance.

Our children do not have to suffer. Vaccines have been highly effective in preventing infectious diseases. For every dollar spent on immunizations, we save an estimated $10 in future health costs, and similar savings are available in prenatal care.

Adolescents and other significant groups disenfranchised from the current health care delivery system need our immediate attention. In the 10 to 18 year-old category, for example, approximately 4.5 million are uninsured. The majority of these children and adolescents are poor or near-poor, live in single-parent households, and have parents who have not completed high school.

Expense is the major reason for the lack of insurance in the adolescent population.

The future of our economic security as a Nation, as individuals, as families, depends on a healthy, well-educated, productive work force. The Carnegie Institute reported that 70 percent of teachers had students whose education was adversely impacted by poor health or nutrition. Without competent, well-trained young adults to move into positions being vacated by our aging population, we will be unable to compete in global markets.

We recognize that the access crisis faced by pregnant women, children and adolescents is caused by cultural, language, geographic, financial, and other barriers to care. There are too few preventive programs for teen suicide and substance abuse. Parents often fail to understand the need for preventive and early acute illness care. Inner cities and many rural areas lack conveniently located physicians or quality child health care services. Low Medicaid reimbursement and excessive paperwork often limit the number of Medicaid patients physicians will accept.

Thus, although lack of adequate health insurance is not the only barrier to care, it is a fundamental obstacle that must be removed.

We must emphasize our concern with the health needs of all segments of our population. This country needs a program that provides universal access to health care for all Americans. The HealthAmerica Act assures that children and pregnant women will be covered in the first phase. We agree that it makes economic and plain common sense to phase in systematic reform by starting with one of the neediest and most vulnerable segments of our population—children and pregnant women.

Our children have a right to appropriate health care. The American Academy of Pediatrics urges prompt congressional action on access to health care so that this Nation can provide children the health care they are entitled to and so desperately need. Let's not permit another Congress to go by without action on this issue.

We certainly look forward to working with you as Congress considers this issue. Thank you.

The CHAIRMAN. Thank you very much for excellent testimony and for your support of the concepts which have been included in the HealthAmerica Act.

I see, Dr. Tuckson, that comparing the summary at the end of your testimony of the position March of Dimes in 1975 and the position today, it sounds like the legislation that we propose is very close to what your recommend.

Dr. TUCKSON. Yes, sir, I think it is extremely close, and I think that the legislation that you recommend has essentially the major elements that ought to be included. The challenge is for those with other considerations to tell us how those other considerations are more important than whether our babies live or die.

The CHAIRMAN. And Dr. Eaton, do you share that view in terms of your own organization?

Dr. EATON. Most certainly. We very much want to see children and pregnant become a priority and, as I said, not be at the bottom of the list, but really move to the top of the public policy agenda. They deserve that.

The CHAIRMAN. Dr. Tuckson, in commenting on the necessity for coverage of services, you mention appropriate nonphysician health professionals, which is included in the bill. The bill also includes a major expansion in the capacity of community health centers, $1.2 billion over the next 5 years, enough to provide service capacity for an additional 9 million underserved Americans.

Would you comment on the fact that just insurance coverage is not enough if there is no physician or other provider available; that we have to create a climate and an atmosphere where we are able to get services, whether it is the nonphysician health professionals or whether it is building additional community health services.

Dr. TUCKSON. I think that is precisely correct. While we cannot underemphasize the absolute first priority of having the financial system in place, that is only a very important but major first step. If we don't have the health professionals and a comprehensive health professional team available to take care of the myriad of problems that have to be attended to, then of course we will not be successful.

So we are very encouraged to see that kind of attention.

To role of the health care team is just as important as the role of the physician himself or herself. Similarly, we are very concerned in inner city America and in rural America whether or not we will in fact have the health care facilities and the personnel available once we take care of the financing issue. So to not speak to both ends of the equation would be shortsighted.

But again in all of this—and our agenda is very complex and broad—we have to, of course, address the finance issue first.

The CHAIRMAN. Stepping back from your role as a spokesman for March of Dimes for a moment and reflecting on your experience here in the District of Columbia, what did lack of adequate health insurance and service providers mean for the children of this city?

Dr. TUCKSON. Well, what it meant was death and disability, to be simple and frank. We lost the money in our budget as a public health department to operate a Wednesday night evening clinic in the poorest section of town. Our reaction to that was to go out as the leadership of the health department and provide the care ourselves on a volunteer basis, every Wednesday night until 9:00 at night. What we learned from the people who came through those doors was very clear. They first could not believe that anybody was

there for them, that we would be open and available for them, and once they knew that they had access to care without regard for financial considerations, they came in extraordinary numbers—and they still do.

So what I have learned is that people will take advantage of health care if in fact it is available to them, and they will cherish and pride that health care. And to not be able to offer it is an absolute disgrace.

The CHAIRMAN. We find that for a low birth weight baby with complications, as I understand, it costs anywhere from $200,000 to $250,000 to take care of that child. We get tens of thousands of those because of the failure of prenatal care.

I have a nephew, Timmy Shriver, who works up in New Haven in the school districts, and he has been working with the development of a prenatal care van that goes out with a very comprehensive group, into the community where they have this extraordinary infant mortality. They are getting a similar kind of response. Just from a bottom line point of view, if you save a couple of low birth weight babies, that is going to finance that whole program up there in outreach—and for us as a society not to understand that—and generally, those outreach programs like home care are the first to get cut back.

Dr. TUCKSON. There is no question that for every dollar we put into prevention, we save three dollars down the road.

The CHAIRMAN. Dr. Eaton, what does it mean in terms of the health consequences when the only family doctor that a child has is in the emergency room?

Dr. EATON. Well, Mr. Chairman, I can address that quite directly because my responsibilities as a pediatrician prior to taking on this year where I spend most of my time in travel had been to administer a very large emergency room in Columbus Children's Hospital. Our visits, I might add, in the last 3 years have increased by probably about 20,000, which tells you something about the utilization of the emergency room I believe as the source of primary care for many families who don't have other access and have no system of payment.

The concern that I have about using the emergency room as the source of one's care is that it is obviously very difficult if not impossible to provide continuity of care; it is very difficult to focus on preventive care, which as you know was a major point in my testimony. I think that ought to be the foundation of whatever it is we're going to do in this country in terms of health care reform. We need to focus on preventive care. When you're going to use the emergency room for those services, that's going to be very, very difficult to provide. So what we need to do is really to remove the financial—and I very much agree with Dr. Tuckson—and the nonfinancial barriers to that care as well, which really require having sufficient capacity within the system and the ability for those families to really access that care.

My strong bias is that those families want health care for their children; they just have major difficulties, really, in finding the mechanism or the source to receive that care. And again, I think that was borne out very well by Dr. Tuckson's experience with the volunteer clinics. They want these services for their children. They

want what is best for their child. And we have an obligation to see that the barriers are removed so that they can access that health care across all ranges because while I have emphasized preventive care, I also want to point out that my clinical experience as a pediatrician has related to children with special health care needs. I could have, from my own experiences and in my own files, generated many, many children and families like Eric and Joshua. I have dealt with them day in and day out.

So we have to have a system in place that is going to address the full spectrum of comprehensive, quality health care for children, adolescents and young adults as well as pregnant women in this country.

The CHAIRMAN. We have, as has been mentioned earlier, focused the primary thrust of the legislation on children as the first priority, as it should be. But even having done that, what is it going to mean to the parents if the parent is not covered and has an illness or some kind of disability? It is one thing doing it for the children, and we all agree on that, but maybe you could just comment on that linkage, because that's going to be the second phase—and it's going to take too long for me, but it's apparently the way we're going to have to do it.

Dr. EATON. Mr. Chairman, I'd be really happy to jump in on that because our position very strongly is that we would like to see universal access to health care for all Americans. That, without a doubt, is the position of the Academy of Pediatrics. The concern that I would have is that if you have a parent who has significant health problems that are undetected or untreated because of lack of health insurance—and again, I think that was evident in some of the points made by our panelists earlier—then that child is going to suffer as a result of that. I think there are significant concerns when the parent has an illness that will impact in a variety of ways on the well-being of the family, and that is certainly going to impact on the child.

With that stated, I will say that our position is that because we obviously have a strong interest in seeing that children and pregnant women receive the kinds of services that they need first, we are very, very eager to see that they be phased in early in whatever plan is going to be implemented.

Dr. TUCKSON. Very briefly also, Senator, I think that advocating for the interests of pregnant women and children is by no means a way of putting that in competition with other Americans. I think we all realize that this is something that is needed for all Americans.

The CHAIRMAN. Very good.

Senator Jeffords.

Senator JEFFORDS. Thank you, Mr. Chairman. I certainly commend you. These have been very excellent hearings. Unfortunately, I couldn't be here yesterday, but I sat up last night and watched you on C-SPAN and watched the whole hearing at that time.

I was over yesterday testifying before the Government Operations Committee in the House on my own proposal for universal access to health care. I have listened with great interest to your testimony and certainly agree with all who have testified today that the primary deficiency in our system is taking care of children

and that the most cost beneficial and, more importantly, socially beneficial aspects of improving our health care come in these provisions in your bill and in others.

So even though I am looking to really going to square one and starting over again in health care, I agree that right now, certainly, the area that we have to improve without waiting the time that will probably be necessary to accomplish that goal is in this specific area.

Mr. Chairman, I'd like to commend you for these hearings and thank the witnesses for their very excellent testimony.

The CHAIRMAN. Thank you very much. Senator Wellstone.

Senator WELLSTONE. First, my thanks to the two of you for your testimony. It is always nice to see professionals testify with so much passion. You obviously care fiercely about health care and are strong and fervent advocates for what we need to do.

Dr. Tuckson, I'd like to explore a couple of issues with you, and I am also going to be interested in the chairman's response to this. In your testimony, you said that you have some very serious reservations about anything that could become an economic deterrent to accessibility, and in that regard you worry about deductibles and coinsurance payment requirements.

I wonder whether or not you could elaborate on that a little bit as to what you are concerned about. My sense is you are worried about its impact on the preventive care part, but I'd like for you to flesh that out. And I'd also like to just prompt a discussion here because I know that that is an issue that we're going to have to deal with in HealthAmerica.

Dr. TUCKSON. Certainly. Very briefly, my experience with this issue is that when I first became an employee of the public health department here, it was my responsibility to in fact construct a financial system that had built into it codeductibles and copayments for care, and I did that early in my career.

When I became the health commissioner and sought advice about why it was that we simply could not get women in for prenatal care and had such horrible infant mortality statistics, all the advocacy groups, all the people who were knowledgeable and who were out in the field, in real life, and who understood what was happening came to me and said it is because of that sign that you put up in your clinics that says this is how much money you have to pay. That sign in the face of poor people who really don't have disposable income was an extraordinary barrier and detriment.

So we took the sign down, and we put a sign up instead that said because we care, free care for all pregnant women who need it and infants up to the age of two who need it, because we care about whether you live or die. By doing that, what I learned was that people came forward who ordinarily would not have.

So for me it is not a theoretical debate; it is very practical, human nature.

Senator WELLSTONE. Mr. Chairman, I'd be interested in a discussion and in your response because I know we have in the HealthAmerica legislation pretty stringent requirements on the deductibles and coinsurance payments. Could I just hear some of your thinking about that?

The CHAIRMAN. Yes. Basically, we don't have the copays or deductibles for the poor, and then it is gradually phased in. Those who fall into the category of the poor don't pay, and for those who are working, it is up to 20 percent.

My sense about it is, as I mentioned earlier—and Dr. Tuckson will remember the studies—you can look at Saskatchewan, where they had a very minimum copayment of, I think it was, one or two dollars for out patient services, and that had virtually no impact on utilization of services. Then they eliminated it, and they found that there were more people coming and that even a very minimum copayment was keeping people away. They made the decision that they were ending up paying more for the people they were keeping away because those people were getting sicker. But as I mentioned before, the studies overwhelmingly show that poor folks and working people don't abuse the system, that it is generally people who have got a lot of time on their hands and they go down and take up a lot of doctors' time. That has historically been the case. I haven't read the recent studies on it, but that has been generally the case, and it makes a good deal of sense to me.

Within that context, it is just ratcheting in terms of the cost and what the traffic will bear. As Senator Mitchell pointed out, I think each of us would devise a health care system somewhat differently—I did 25 years ago and still believe in it, but we have missed some important opportunities, I feel, and I don't want to miss any more.

Senator WELLSTONE. I just raised that question because I thought it was an interesting point for us to discuss. I don't want the opportunity to be missed, either. As I think about the legislation that is before us and how to be a part of this discussion and framing this legislation, I still have concern about that, I think for the same reasons that you do, Dr. Tuckson—about the deductibles and the coinsurance payments.

You also talked about the whole issue of accessibility, and we heard about this in the previous panel—it's not just poor people. That's the point. There are people just a little bit above. I just think this has become a huge political majority question in this country.

The second question I'd raise with you, Dr. Tuckson, is you pointed out—and this may have been in your written testimony because you summarized your written testimony today—that some of the important preventive and special services that are important to maternal and child care don't fit easily into the traditional insurance mold. I want again to ask you to flesh that out a bit for me.

Dr. TUCKSON. Precisely. It is extremely important that we learn to value the work of our full health care team, the allied health professionals, the people who are doing the nutrition, the counselors and so forth. Those people are just as important in the survival of infants, perhaps, as some of the more traditionally understood or recognized health professionals. So it is our concern that when we talk about comprehensive care—and even though we in the medical profession understand it, we don't want to just give lip service to that—this is very, very important, and we have to find a way, especially in the pregnancies that are complicated by so many other socioeconomic insults.

We know right now, Senator, that if all the women who are pregnant and smoke cigarettes stopped today, we could save 4,000 babies' lives. Now, it is extremely important, then, that we make available something as "simple" as smoking cessation programs as part of what we in fact provide as insurance, because if we do that, 4,000 lives is eminently worth such an investment. It is just that kind of thing that we're trying to get to.

Senator WELLSTONE. That's a bridge for a question that I wanted to ask Dr. Eaton. I'm just now trying to get clear on all of this conceptually. With the HealthAmerica bill, if the problem is that if you're in the public part, some of the preventive services, as I understand it, are covered, but if you are in the "play or pay" part, the employer-employee part, then I think you testified that dental care, prescription drugs and the EPSDT are not covered; is that correct?

Dr. EATON. Yes. I think the key point I was making is that the EPSDT services, which really are basic and quite comprehensive preventive health care, are really available to those children and adolescents in the public program, but are not stipulated as part of the private.

Senator WELLSTONE. But not in the employer-employee part.

Dr. EATON. Right. And our feeling is that that spectrum of services, which now is part of the Medicaid program, is really a very comprehensive set of services that will really aid in terms of prevention, and also early identification and intervention when a developmental problem, for example, is identified or a vision or a hearing problem. So that it is very important that we provide the full spectrum of comprehensive preventive care to all children. And we would like to see that applied to the private sector as well because it is such an excellent program.

Senator WELLSTONE. And also prescriptions and dental——

Dr. EATON. Well, the prescription drugs is certainly another issue that would be tremendously helpful, because again——

Senator WELLSTONE. Spell out why that would be important to the lives of children to include that because it is not right now.

Dr. EATON. Well, because many children with special health care needs in particular, or children who have acute illness, are really going to have to have those medications in order to really either treat or intervene in a particular problem that they are having. The child with asthma would be a very good example, or the child with epilepsy who was highlighted in the panel today.

Dr. TUCKSON. Senator, I would also just say as Dr. Eaton develops that the most frustrating thing in the world is to be able to make the diagnosis, devise the treatment protocol, sit there and write the prescription, and then know, as Dr. Eaton and I have seen, that the family cannot afford the medication, which means that everything that you've done all the way up to that point is useless.

Dr. EATON. And in some instances, they are very reluctant to even tell you that. I mean, they are concerned about the cost, but they don't even share that with you.

Senator WELLSTONE. And the dental care—I understand all sorts of projections have been made into this and so on, but again I think it is an interesting question. You have spelled out—and

forget the politics of it—as doctors, I'm just taking what you've just said, Dr. Tuckson, you've spelled out your professional opinion about what happens when there are these gaps. I think we've got to include—the dental care part is not included in the employer-employee part; is that right?

Dr. EATON. That's my understand.

Senator WELLSTONE. It is in the public part; is that correct?

The CHAIRMAN. Yes.

Senator WELLSTONE. In the spirit of what we've been doing in this week's hearings, and one of the things I like the most about these hearings is that we have had a variety of different testimony, but we have not gotten bogged down in statistics. It has been real, and I really thank you, Mr. Chairman. I don't think I will ever tire of having people come in and talk about what is happening to them, because that is ultimately what it is about.

But just to add an example, I can remember meeting a child—I think she was about 10 years old—with an abscess from not being able to see the dentist. She's supposed to be able to learn in school? What is the basis for excluding it?

The CHAIRMAN. Cost.

Senator WELLSTONE. Well, can I express my frustration about that and say that we need to strengthen that?

The CHAIRMAN. Sure.

Dr. EATON. If I may just interject here, obviously, we want to see the full spectrum of preventive care for all children and pregnant women, and clearly, there are limitations. Now, our position as health professionals is to be here and say to you that we think that children, adolescents and pregnant women in this country need all of these services.

Senator WELLSTONE. Well, let me just ask one more question, and I know we're running out of time. And I know you are here to support the HealthAmerica bill, which is fine; I know you are here to speak about it. But in the spirit of really supporting that bill, I'd like for you to be just very strong about what you think should be done.

What do we lose when we leave out the EPSDT part and the dental part and the prescription part on the employer-employee coverage? What is the loss for children? It costs more—right? Everybody knows that. OK. So what is the other cost? What is the cost to children in this country?

Dr. EATON. I guess what we'd have to say is there obviously is a cost to children and pregnant women in this country, but I also must say that we know there is a reality in terms of how much you can afford to pay, what the system can afford in terms of covering all those services.

Senator WELLSTONE. Can I interrupt you?

Dr. EATON. Sure.

Senator WELLSTONE. This is a good chairman. He lets me do this. He lets me just take my questions in the direction I want to. I hear about reality every day I am here in Washington. I always hear about what is realistic. But I asked you as a professional, as an M.D., as a pediatrician, to tell me what the loss is when we don't include this in the coverage to children. I have heard the discus-

sion about what is politically realistic. I am asking you your professional M.D. judgment.

Dr. EATON. Without going through the entire testimony once again, the EPSDT program primarily is going to focus on preventive care. That is really the mainstay. Now, when a child is identified as having a problem, you are going intervene and obviously remediate that problem as well. Dental services are certainly very critical, and we all know that dental problems are one of the major problems facing children. The reality of it is, however, that one needs to make judgments about what can and cannot be included. And I would say at this point I'd love to see, and the Academy of Pediatrics would like to see, all of those services included, but we are also realistic, and we recognize that there are constraints within the system that may not enable that to be available.

Senator WELLSTONE. My understanding actually is that dental and prescription are not in the public part, either.

The CHAIRMAN. Well, it is covered under Medicaid now for 100 percent of the services for those under 100 percent of the poverty level. I was just checking with staff, and I guess there are a few States that do not, but most of them do, and if they do, we would continue to require that they not reduce those services. But as a general concept beyond that——

Senator WELLSTONE. So it would be just what States have already, then.

The CHAIRMAN [continuing]. It would be just what the States have. But it is tied to the 100 percent of the poverty level; it doesn't cover those who are just outside or on the margin.

Senator WELLSTONE. Do you want to finish up, Dr. Tuckson?

Dr. TUCKSON. Very briefly, I would just say that I appreciate the theme that you are sounding, and certainly we at this table and all of us realize that this is going to be such difficult legislation to get through, and we just ultimately want this to get passed. We want to see progress, and we want to see it now. However, if you continue to give us the invitation to say "yes", we would love it if we could reach a national consensus that would include all of the basic things that would give our children a chance to survive.

The early and periodic screening and detection and treatment of disease to identify young children who have multiple problems early in their lives, to be able to finance that and then, even better, to be able to finance the care for those disorders that we in fact do pick up because of our screening—that's a wonderful thing for a nation as civilized as ours to be able to accomplish.

The bottom line becomes what can we agree on, what can we get a consensus on and move forward on, and I would love to see that consensus be as broad as possible given the discussion that you've just engaged in.

Senator WELLSTONE. Well, let's keep pushing the definition of what is realistic about what the consensus will be.

Thank you very much.

Dr. EATON. We'll do that.

The CHAIRMAN. I think it is useful to point out that all aspects of both the private and the public programs have included for those who are 100 percent of poverty those recommendations of the Society for Well-Baby Care. So all of those have been included.

Dr. EATON. And we very much appreciate that.

The CHAIRMAN. OK. We'll be calling on you, and we appreciate very, very much your testimony. Dr. Tuckson, I am delighted to see you, and I appreciate our other visits.

Senator Wellstone is going to be traveling around the District with you as well to see some of those clinics.

I thank you very much.

Dr. TUCKSON. Thank you, Senator.

[Additional statements submitted for the record follows:]

PREPARED STATEMENT OF DR. DAVID SATCHER, PRESIDENT, ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

BACKGROUND STATEMENT

In his January 29, 1991 State of the Union address, President Bush stated that "good health care is every American's right and every American's responsibility". The Association of Minority Health Professions Schools (AMHPS) supports President Bush's assertion that health care for every American is a right and not a privilege. In order to make that right a reality, AMHPS strongly supports reform of our national health care system which insures health care services to anyone who needs access to health care. Access to health care should not relate to one's ability to pay. The issue must be placed on the national agenda immediately.

Disparities in access to health care is the dominant factor which accounts for the growing disparity in the health status between blacks and other disadvantaged minorities and the general population of the U.S. Improved access to health care is of paramount importance in achieving the AMHPS mission to improve the health status of minority and disadvantaged persons and must be the primary component of health care reform. National health care reform is absolutely essential in order to address the crises of lack of access to proper health care for minorities. It is important to note that in the last few years policy makers have debated the merits of various health reform plans. The federal government must demonstrate leadership by addressing this crises now.

HEALTH CARE REFORM PROPOSALS

Recently, there has been significant debate about various health care reform programs. The current debate has not addressed the crises because no health reform program appears close to being enacted by the Congress. The process for enacting reform appears to have ended before it began. Several reports that attempt to reach a consensus on the best process of health care reform include the Health Leadership Commission which issued two minority reports after two years of consideration.

One report from Corporate America felt that the Commission's proposal put too much money into the hands of providers, especially physicians, by providing universal access programs with payer pools at the state level. This report felt that more emphasis should be placed on cost containment and less emphasis on increasing access.

Another minority report from the American Medical Association (AMA) felt that the Leadership Commission's proposal was too critical and too negative about physicians in its analysis of the present health care system. Other reports on this topic, ranging from the National Association of Social Workers to the U.S. Bipartisan Commission on Comprehensive Health Care clearly indicate that there are too many ramifications and too many conflicting political agendas to allow groups with large constituencies to successfully develop a viable proposal. Therefore, we are recommending a different process to developing a health care reform proposal—one in which President Bush and his Secretary for Health and Human Services would define some desired outcomes such as universal access, measures to control cost, and a program to evaluate appropriateness and quality of care, as well as some built-in economic and other incentives.

Given the defined objectives or desired outcomes, a group of people should be brought together based on their technical skills not based on their representation of different organizations or constituents. Given their technical skills, they should be asked to develop a system that would best provide the outcomes which have been defined and, at the same time, have a measure of political feasibility built into it.

This technical group, or task forces must be politically neutral in coming up with a proposed program or programs.

Health Status Disparity

Blacks and other disadvantaged minorities do not enjoy the same health status as other Americans. The 1985 Health and Human Services Secretary's Task Force Report on Black and Minority Health demonstrated that there indeed was and is a significant health status disparity among blacks and other minorities as compared to the general population of the U.S.

Among the more sobering facts revealed by the report were:

—Life expectancy of blacks is nearly 6 years less than that of whites;
—Among blacks, infant mortality occurs at a rate of almost 20 per 1,000 live births, twice that of whites;
—Blacks suffer disproportionately higher rates of cancer, cardio-vascular disease and stroke, chemical dependency, diabetes, homicide and accidents; and
—Each year almost 60,000 excess deaths occur among blacks when compared to whites.

Since this historic report by the Secretary in 1985 the health status gap has widened. The National Center for Health Statistics recently reported that black life expectancy has decreased from 69.7 in 1984 to 69.2 in 1988. AIDS, which was not even mentioned in the 1985 report is now a leading cause of death and disproportionately affects blacks and other minorities—minorities who constitute 24% of the U.S. population but 45% of our AIDS victims.

AMHPS Institutions

AMHPS is comprised of 8 historically black health professions schools which have trained 40% of the nation's black physicians, 40% of the nation's black dentists, 50% of the nation's black pharmacists, and 75% of the nation's black veterinarians.

AMHPS institutions each has a student body that is represented by more than 50% minorities. Yet while blacks constitute 12 percent of the population, only 3 percent of physicians are black and only 5 percent of medical school graduates (since 1980) have been black. This is important in that data clearly show that blacks and other minorities are more likely to practice in underserved communities, more likely to care for other minorities and more likely to accept patients who are Medicaid recipients or otherwise poorer than the general population. While the federal government's commitment to supporting historically black health professions schools is beginning to address the disparity in health status between minority and non-minority populations, AMHPS believes that in addressing the enormous problem of this health status disparity, a firm commitment from the federal government to the users and pavers of health services must be made.

AMHPS institutions have been at the vanguard of addressing the enormous need to close the gap in the health status disparity between the minority and majority populations, to increasing the number of minorities in the health professions and to serving the indigent and the underserved. There is a direct correlation in between these objectives and the causes of these problems which gave rise to our institutions' objectives. These objectives all emanate from the historical and tremendous problem of disparities between minority and majority populations in access to health care. For many years our institutions have been involved in minority health professional education and have established an outstanding track record in serving the underserved.

Yet these institutions have paid a price for their missions and their commitments. While the average medical school gets 40 percent of its revenue from patient care, the minority medical schools often lose money in patient care due to the fact that the majority of their patients are usually poor. As access problems worsen for the poor, these institutions' plights also worsen. Cutbacks in Medicaid and Medicare, in the 1980's, severely impacted these institutions and their related hospitals. The overwhelming majority of historically black hospitals closed during the 1980s, and the approximately ten remaining are all suffering from deficit operations. The medical education programs have likewise suffered. Recently, a Council of Graduate Medical Education (COGME) report demonstrated that many academic health centers have suffered a significant decline in their operational margins during the 1980s. It is clear that those that are involved most heavily in the care of the poor now have negative margins that are continuing to decline.

Health Care Reform is Urgent

There are approximately 37 million Americans who have no health insurance. Millions of disadvantaged Americans are not able to pay and receive health care. This has contributed significantly to the now unacceptable cost and growth of health care in this country. Health care costs have grown faster than inflation every year since 1980 and have grown 11 percent since 1988. Additionally, health programs as a percentage of the federal budget continue to increase while costs have increased by almost half to large and medium-sized companies. Employers who do provide health insurance, public hospitals and people with health insurance subsidize the costs of uncompensated care. It is the absence of health care for minorities and the poor which results in skyrocketing health insurance premiums for the middle-class.

This points out that health care reform cannot be accomplished piecemeal. Rather what is needed is a complete overhaul of our health care system to provide universal access, cost-containment and quality assessment.

The current situation is unacceptable and demands urgent action by the federal government. Most importantly, every day that health care reform is delayed, blacks die. Every day that health care reform is delayed, minority health professions institutions experience greater financial instability.

From 1977 to 1987 the relative increase in the number of persons without insurance was greater among minorities than whites. During that time span, the number of uninsured whites increased by about 28 percent while the number of uninsured blacks nearly doubled from four to seven million and the number of uninsured hispanics increased three-fold from two to six million. Thirty-five percent of hispanics under age 65 and 26 percent of blacks, were uninsured in 1987 compared to 15 percent of whites. The increase between 1977 and 1987 in the proportion of uninsured hispanics was five times the increase for whites. For blacks, the increase was twice that for whites. The declining proportion of blacks with health insurance is mainly due to a reduction in private insurance, with public coverage declining. As the 1985 Secretary's Task Force on Black & Minority Health revealed, "Many . . . minorities tend to rely on Medicaid and charity care for their medical treatment because they have no other sources of care or ways to finance that care . . ." Further, minorities are disproportionately poor and unemployed, consequently they disproportionately experience the barriers to health care associated with poverty. Under the current system of health care insurance, poor people are too often excluded from the process. There is a correlation between the problem of criteria for eligibility into the process of health cost reimbursement and the problem of poor access to health care by the poor. Health care coverage is often provided through employment, so for minorities access to health care is often obstructed through unemployment and through employment with businesses such as many of those in the service industry that do not provide health insurance. Many other barriers exist as a result of poverty which prevent access to health care, including lack of available health care personnel, transportation, and other cultural barriers. Economic and other barriers to the receipt of health care must be eliminated. Universal access is every American's right. Finances must not be a barrier to health care.

General Recommendations

AMHPS believes that the following general criteria are essential elements to any health care reform plan. The plan must provide (1) universal, comprehensive coverage. It must (2) maximize cost efficiency through cost containment and it must (3) maintain a free-enterprise component.

Healthy People 2000: National Health Promotion and Disease Prevention Objectives, submitted by the Department of Health and Human Services just last year, outlined basic goals for health improvements—including the elimination of disparities among population groups and access to necessary preventive services for everyone. Many health problems are associated with poverty, such as lack of access to basic health care for the underserved which causes these disparities and it will only be through health care reform that these problems can begin to be addressed.

National Health Care Reform must also maximize cost efficiency. Health care costs have risen beyond control. The U.S. spends over 600 billion dollars per year on health care. Per capital health spending is greater in the United States than in Canada, yet our nation has a lower life expectancy and a higher rate of infant mortality. A national health care reform program should stabilize health expenditures as a percentage of the national income and reduce the problems of uncompensated care and individual burdens of catastrophic illness. In order to achieve these objectives such a plan must redirect available resources to the weaknesses of the system.

Too often, funding that was originally intended to help the indigent does not reach the indigent. The flow of resources to the underserved is not being appropriately applied. A redirection of resources to institutions that provide quality care to the disadvantaged, to the underserved and to the indigent, is an important component of any national health care reform program. There must also be a focus on preventive medicine and primary care.

Finally, a national health care reform program must maintain a free-enterprise component, that would allow for the continued provision of health care services by the most competent and accessible individuals or systems, at the most affordable and reasonable cost. AMHPS is not calling for universal health insurance.

THE PROCESS

In the last year alone, several major health care associations, as well as the Pepper Commission have developed national health reform programs. Yet without Executive leadership and differences over the various aspects of the several proposals, no. work has begun in Congress to enact a new health coverage program. Whether the means toward achieving universal access to health coverage include incentives for employers to provide health care coverage and support for public programs that provide access to basic health care benefits for the uninsured or not, what is important is to recognize that alleviating the problem of the health status disparity between disadvantaged minorities and the general population is crucial. A technical agreement must be reached prior to implementation by Congress.

Black Americans are experiencing a health care crisis. The President and the Congress must exert leadership and enact legislation to improve access to health care for minorities. Action must not be delayed any longer.

The CHAIRMAN. The committee stands in recess.

[Whereupon, at 11:50 a.m., the committee was adjourned.]

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